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42 CFR Parts 412, 413, and 485

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, and 485

[HCFA–1118–P]

RIN 0938–AK09

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment system for operating costs to: implement applicable statutory requirements, including a number of provisions of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (Public Law 106–113); and implement changes arising from our continuing experience with the system. In addition, in the Addendum to this proposed rule, we are describing proposed changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes would be applicable to discharges occurring on or after October 1, 2000. We also are setting forth proposed rate-of-increase limits as well as proposed policy changes for hospitals and hospital units excluded from the prospective payment systems.

We are proposing changes to the policies governing payments to hospitals for the direct costs of graduate medical education and payments to disproportionate share hospitals, sole community hospitals, and critical access hospitals to implement changes made by Public Law 106–113.

Finally, we are proposing a new condition of participation on organ, tissue, and eye procurement for critical access hospitals that parallels the condition of participation that we previously published for all other Medicare-participating hospitals.

DATES: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on July 5, 2000.

ADDRESSES: Mail written comments (an original and three copies) to the following address only: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1118–P, P.O. Box 8010, Baltimore, MD 21244–1850.

If you prefer, you may deliver by courier your written comments (an original and three copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to those addresses may be delayed and could be considered late.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1118–P.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

For comments that relate to information collection requirements, mail a copy of comments to the following addresses:

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: John Burke HCFA–1118–P; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer.

FOR FURTHER INFORMATION CONTACT:

Steve Phillips, (410) 786–4531, Operating Prospective Payment, DRG, Wage Index, Reclassifications, and Sole Community Hospital Issues.

Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, Graduate Medical Education and Critical Access Hospital Issues.

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

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I. Background

A. Summary

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system. Under these prospective payment systems, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

Certain specialty hospitals are excluded from the prospective payment systems. Under section 1886(d)(1)(B) of the Act, the following hospitals and hospital units are excluded from the prospective payment systems: psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals. For these hospitals and units, Medicare payment for operating costs is based on reasonable costs subject to a hospital-specific annual limit.

Under sections 1820 and 1834(g) of the Act, payments are made to critical

access hospitals (CAHs) (that is, rural nonprofit hospitals or facilities that meet certain statutory requirements) for outpatient services on a reasonable cost basis. Reasonable cost is determined under the provisions of section 1861(v)(1)(A) of the Act and existing regulations under parts 413 and 415.

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year.

The regulations governing the hospital inpatient prospective payment system are located in 42 CFR part 412. The regulations governing excluded hospitals and hospital units are located in parts 412 and 413, and the GME regulations are located in part 413.

On July 30, 1999, we published a final rule in the **Federal Register** (64 FR 41490) that implemented both statutory requirements and other changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs, as well as changes addressing payment for excluded hospitals and payments for GME costs. Generally, these changes were effective for discharges occurring on or after October 1, 1999. Correction notices for the July 30, 1999 final rule relating to the wage index and geographic adjustment factor were issued in the **Federal Register** on January 12, 2000 (65 FR 1817) and February 7, 2000 (65 FR 5933).

On November 29, 1999, the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999, Public Law 106–113, was enacted. Public Law 106–113 made a number of changes to the Act relating to prospective payments to hospitals for inpatient services and payments to excluded hospitals. This proposed rule would implement amendments enacted by Public Law 106–113 relating to FY 2001 payments for GME costs and FY 2001 payments to disproportionate share hospitals (DSHs), sole community hospitals (SCHs), and CAHs. These changes are addressed in sections IV. and VI. of this preamble.

Other provisions of Public Law 106–113 that relate to Medicare payments to hospitals effective prior to October 1, 2000, will be addressed in a separate interim final rule with comment period. The provisions that will be included in the interim final rule are summarized in section I.C. of this preamble.

Public Law 106–113 also amended section 1886(j) of the Act, which was added by section 4421 of the Balanced Budget Act of 1997 (Public Law 105–33). Section 1886(j) of the Act provides for a fully implemented prospective payment system for inpatient rehabilitation hospitals and rehabilitation units, effective for cost reporting periods beginning on or after October 1, 2002, with provisions for payments during a transitional period of October 1, 2000 to October 1, 2002, based on target amounts specified in section 1886(b) of the Act. In section VI of this preamble, we describe the impact of this provision on the proposed changes applicable to excluded hospitals and units in this proposed rule. We are issuing a separate notice of proposed rulemaking to implement the prospective payment system for inpatient rehabilitation hospitals and units.

B. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital inpatient prospective payment system for operating costs. We are not proposing any policy changes relating to payments for capital-related costs under the hospital inpatient prospective payment system in FY 2001. Our proposed changes relating to capital-related costs include only changes to the amounts and factors for determining the rates for capital-related costs for FY 2001. We also are proposing changes relating to payments for GME costs and payments to excluded hospitals and units, DSHs, SCHs, and CAHs. This proposed rule would be effective for discharges occurring on or after October 1, 2000.

The following is a summary of the major changes that we are proposing to make:

1. Proposed Changes to the DRG Reclassifications and Recalibrations of Relative Weights

As required by section 1886(d)(4)(C) of the Act, we adjust the DRG classifications and relative weights annually. Our proposed changes for FY 2001 are set forth in section II. of this preamble.

2. Proposed Changes to the Hospital Wage Index

In section III. of this preamble, we discuss proposed revisions to the wage index and the annual update of the wage data. Specific issues addressed in this section include the following:

- The FY 2001 wage index update, using FY 1997 wage data.
- The transition to excluding from the wage index Part A physician wage costs that are teaching-related, as well as resident and Part A certified registered nurse anesthetist (CRNA) costs.
- Revisions to the wage index based on hospital redesignations and reclassifications.

3. Other Decisions and Proposed Changes to the Prospective Payment System for Inpatient Operating and Graduate Medical Education Costs

In section IV. of this preamble, we discuss several provisions of the regulations in 42 CFR Parts 412 and 413 and set forth certain proposed changes concerning the following:

- Postacute care transfers.
- Sole community hospitals.
- Rural referral centers.
- Changes relating to the indirect medical education adjustment.
- Changes relating to the DSH adjustment and collection of data on uncompensated costs for services furnished in hospitals under the prospective payment system.
- Medicare Geographic Classification Review Board (MGCRB) classifications.
- Payment for the direct costs of GME.

4. Last Year of Transition Period for the Prospective Payment System for Capital-Related Costs

In section V. of this preamble, we discuss FY 2001 as the last year of a 10-year transition period established to phase-in the prospective payment system for capital-related costs for inpatient hospital services.

5. Proposed Changes for Hospitals and Hospital Units Excluded from the Prospective Payment Systems

In section VI. of this preamble, we discuss the following proposals concerning excluded hospital and hospital units and CAHs:

- Limits on and adjustments to the proposed target amounts for FY 2001.
- Development of prospective payment system for inpatient rehabilitation hospitals and units.
- Continuous improvement bonus payments.
- Clarification that the 5-percent threshold used in calculating an excluded hospital's cost per discharge is based only on Medicare inpatients discharged from the hospital-within-a-hospital.
- All-inclusive payment rate option for CAHs.
- Condition of participation for CAHs relating to organ, tissue, and eye procurement.

6. Determining Prospective Payment Operating and Capital Rates and Rate-of-Increase Limits

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2001 prospective payment rates for operating costs and capital-related costs. We also address update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2001 for hospitals and hospital units excluded from the prospective payment system.

7. Impact Analysis

In Appendix A, we set forth an analysis of the impact that the proposed changes described in this proposed rule would have on affected entities.

8. Capital Acquisition Model

Appendix B contains the technical appendix on the proposed FY 2001 capital cost model.

9. Report to Congress on the Update Factor for Hospitals under the Prospective Payment System and Hospitals and Units Excluded from the Prospective Payment System

Section 1886(e)(3) of the Act requires the Secretary to report to Congress on our initial estimate of a recommended update factor for FY 2001 for payments to hospitals included in the prospective payment systems, and hospitals excluded from the prospective payment systems. This report is included as Appendix C to this proposed rule.

10. Proposed Recommendation of Update Factor for Hospital Inpatient Operating Costs

As required by sections 1886(e)(4) and (e)(5) of the Act, Appendix D provides our recommendation of the appropriate percentage change for FY 2001 for the following:

- Large urban area and other area average standardized amounts (and hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals) for hospital inpatient services paid for under the prospective payment system for operating costs.
- Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the prospective payment system.

11. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, the Medicare Payment Advisory Commission (MedPAC) is required to submit a report to Congress, not later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies. This annual report makes recommendations concerning hospital inpatient payment policies. In section VII. of this preamble, we discuss the MedPAC recommendations and any actions we are proposing to take with regard to them (when an action is recommended). For further information relating specifically to the MedPAC March 1 report or to obtain a copy of the report, contact MedPAC at (202) 653–7220.

C. Provisions of Public Law 106–113 To Be Included in Interim Final Rule With Comment Period

As we have indicated under section I.A. of this preamble, we are planning to publish an interim final rule with comment period to address provisions of Public Law 106–113 that are effective prior to October 1, 2000. This interim final rule with comment period will be issued prior to the publication of the hospital inpatient prospective payment system final rule by August 1. A summary of the provisions of Public Law 106–113 that will be addressed in the interim final rule with comment period follows:

- Section 111(b), which provides for an additional payment to teaching hospitals equal to the additional amount the hospital would have been paid for FY 2000 if the IME adjustment formula under section 1886(d)(5)(B) of the Act (which reflects the higher indirect operating costs associated with GME) for FY 2000 had remained the same as for FY 1999. (Section 111(a) also changed the IME adjustment formula for discharges occurring during FY 2001 and for discharges occurring on or after October 1, 2001, which is addressed in section IV.D. of this preamble.)
- Section 121, which amended section 1886(b)(3)(H) of the Act to provide for an appropriate wage adjustment to the cap on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. We will address the wage adjustment to the FY 2000 caps in the interim final rule. (The wage adjustment to the FY 2001 caps is discussed in section VI. of this preamble.)
- Section 312, which amended section 1886(h)(5) of the Act to provide that, effective July 1, 2000, in determining the cap on the number of residents for GME and IME costs, the period of board eligibility and the initial residency period for child neurology is the period of board eligibility for pediatrics plus 2 years. This provision applies on and after July 1, 2000, to residency programs that began before, on, or after November 29, 1999.
- Section 401(a), which amended section 1886(d)(8) of the Act to direct the Secretary to treat certain hospitals located in urban areas as being located in rural areas of their State if the hospital meets statutory criteria and files an application with HCFA. This provision is effective on January 1, 2000.
- Section 401(b), which contains conforming changes to incorporate the reclassifications under the amendments made by section 401(a) of Public Law 106–113 to outpatient hospital services (section 1833(t) of the Act) and the CAH statute (section 1820(c)(2)(B)(i) of the Act). This provision is effective on January 1, 2000.
- Section 403(a), which amended section 1820(c)(2)(B)(iii) of the Act to delete the 96-hour length of stay restriction on inpatient care in a CAH and to authorize a period of stay that does not exceed, on an annual basis, 96 hours per patient. This provision is effective on November 29, 1999.
- Section 403(b), which amended section 1820(c)(2)(B)(i) of the Act to allow for-profit hospitals to qualify for CAH status. This provision is effective on November 29, 1999.
- Section 403(c), which amended section 1820(c) of the Act to allow hospitals that have closed within 10 years prior to November 29, 1999, or hospitals that downsized to a health clinic or health center, to be designated as CAHs if they meet the established criteria for designation.
- Section 403(e), which amended sections 1833(a)(1)(D)(i) and 1833(a)(2)(D)(i) the Act to eliminate the Medicare Part B deductible and coinsurance for clinical diagnostic laboratory tests furnished by a CAH on an outpatient basis. This provision is effective with respect to services furnished on or after November 29, 1999.
- Section 403(f), which amended section 1883 of the Act to reinstate the right of CAHs that meet applicable requirements to enter into ''swing-bed'' agreements.
- Section 404, which amended section 1886(d)(5)(G) of the Act to extend the Medicare-dependent, small rural hospital program for 5 years, from FY 2001 through FY 2005. Section 404 also amended section 1886(b)(3)(D) of the Act as a conforming change to make the 5-year extension applicable to the

target amounts for Medicare-dependent, small rural hospitals.

• Section 407(a)(1), which amended section 1886(h)(4)(F) of the Act to direct the Secretary, for purposes of determining a hospital's FTE cap for direct GME payments, to count an individual to the extent that the individual would have been counted as a primary care resident for purposes of the FTE cap but for the fact that the individual was on maternity or disability leave or a similar approved leave of absence. Section 407(a)(2) made a corresponding amendment to section 1886(d)(5)(B)(v) of the Act relating to the IME adjustment. The provision relating to direct GME is effective with cost reporting periods beginning on or after November 29, 1999. The provision relating to the IME adjustment applies to discharges occurring in cost reporting periods beginning on or after November 29, 1999.

• Section 407(b)(1), which amended section 1886(h)(4)(F)(i) of the Act to provide that a rural hospital's direct FTE count for direct GME may not exceed 130 percent of the number of unweighted residents that the rural hospital counted in its most recent cost reporting period ending on or before December 31, 1996. Section 407(b)(2) made a similar change to section 1886(d)(5)(B)(v) of the Act relating to the IME adjustment. The provision relating to direct GME applies to cost reporting periods beginning on or after April 1, 2000. The provision relating to the IME adjustment applies to discharges occurring on or after April 1, 2000.

• Section 407(c), which amended sections 1886(h)(4)(H) and 1886(d)(5)(B)(v) of the Act to allow a non-rural hospital that establishes separately accredited approved medical residency training programs (or rural training tracks) in a rural area or has an accredited training program with an integrated rural track, to receive an FTE cap adjustment for purposes of direct GME and IME. The provision is effective with cost reporting periods beginning on or after April 1, 2000 for direct GME, and with discharges occurring on or after April 1, 2000 for IME.

• Section 407(d) addresses the situation where residents were training in a residency training program at a Veterans Affairs hospital and then were transferred on or after January 1, 1997 and on or before July 30, 1998, to a non-Veterans Affairs hospital because the program in which the residents were training would lose its accreditation by the Accreditation Council on Graduate Medical Education (ACGME) if the residents continued to train at the facility. In this scenario, the non-Veterans Affairs hospital may receive a temporary adjustment to its 1996 FTE cap to include in its FTE count those residents who were transferred from the Veterans Affairs hospital. This provision applies as if it was included in the enactment of Public Law 105–33, that is, for GME with cost reporting periods beginning on or after October 1, 1997, and for IME, discharges occurring on or after October 1, 1997. If a hospital is owed payments as a result of this provision, payments must be made immediately.

• Section 541, which amended section 1886 of the Act to provide an additional payment to hospitals that receive payments under section 1861(v) of the Act for approved nursing and allied health education programs to reflect utilization of Medicare+Choice enrollees. This provision is effective for portions of cost reporting periods in a year beginning with calendar year 2000.

II. Proposed Changes to DRG Classifications and Relative Weights

A. Background

Under the prospective payment system, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual hospital's payment rate per case and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in all DRGs.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The proposed changes to the DRG classification system, and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 2000, are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). Medicare fiscal intermediaries enter the information into their claims processing systems and subject it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG.

After screening through the MCE and any further development of the claims, cases are classified into the appropriate DRG by the Medicare GROUPER software program. The GROUPER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). It is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights.

In the July 30, 1999 final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for the use of particular data to be feasible, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the data submitted. Generally, however, a significant sample of the data should be submitted by August 1, approximately 8 months prior to the publication of the proposed rule, so that we can test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted no later than December 1 for consideration in conjunction with the next year's proposed rule.

Currently, cases are assigned to one of 501 DRGs (including one DRG for a diagnosis that is invalid as a discharge diagnosis and one DRG for ungroupable diagnoses) in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body (for example, MDC 6 (Diseases and Disorders of the Digestive System)); however, some MDCs are not constructed on this basis since they

involve multiple organ systems (for example, MDC 22 (Burns)).

In general, cases are assigned to an MDC based on the principal diagnosis, before assignment to a DRG. However, there are five DRGs to which cases are directly assigned on the basis of procedure codes. These are the DRGs for liver, bone marrow, and lung transplants (DRGs 480, 481, and 495, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

Within most MDCs, cases are then divided into surgical DRGs (based on a surgical hierarchy that orders individual procedures or groups of procedures by resource intensity) and medical DRGs. Medical DRGs generally are differentiated on the basis of diagnosis and age. Some surgical and medical DRGs are further differentiated based on the presence or absence of complications or comorbidities (CC).

Generally, the GROUPER does not consider other procedures; that is, nonsurgical procedures or minor surgical procedures generally not performed in an operating room are not listed as operating room (OR) procedures in the GROUPER decision tables. However, there are a few non-OR procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

The changes we are proposing to make to the DRG classification system for FY 2001 and other issues concerning DRGs are set forth below. Unless otherwise noted, our DRG analysis is based on the full (100 percent) FY 1999 MedPAR file (bills received through December 31, 1999 for discharges in FY 1999).

2. MDC 5 (Diseases and Disorders of the Circulatory System)

In the August 29, 1997 final rule with comment period (62 FR 45974), we noted that, because of the many recent changes in heart surgery, we were considering conducting a comprehensive review of the MDC 5 surgical DRGs. In the July 31, 1998 final rule with comment period (63 FR 40956), we did adopt some changes to the MDC 5 surgical DRGs. Since that time, we have received inquiries on a continuing basis regarding these DRGs. We have continued to review Medicare claims data and, based on our analysis, we are proposing the following DRG changes in MDC 5:

a. Heart Transplant (DRG 103)

As previously stated, cases are generally assigned to an MDC based on principal diagnosis and subsequently assigned to surgical or medical DRGs included in that MDC. However, cases involving liver, bone marrow, and lung transplants (DRGs 480, 481, and 495, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483) are directly assigned on the basis of procedure codes. Cases assigned to these DRGs before classification to an MDC are referred to as pre-MDC. However, cases involving heart transplants are currently assigned first to MDC 5 and then to DRG 103.

Currently, when a bone marrow transplant and a heart transplant are performed during the same admission, the case is assigned to DRG 481 (Bone Marrow Transplant). Because bone marrow transplant cases are first classified to pre-MDC, while heart transplants are first assigned to MDC 5, the bone marrow transplant assumes precedence in the assignment of the case to a DRG. However, payment for DRG 481 is substantially less than DRG 103. For FY 2000, the relative weight for DRG 103 is 19.5100, while the relative weight for DRG 481 is 8.7285.

We reviewed the FY 1999 MedPAR file containing bills through December 31, 1999 and found no cases in which a bone marrow transplant and a heart transplant were performed in the same admission. However, to ensure appropriate DRG assignment of these cases, we are proposing that the heart transplant DRG, which encompasses combined heart-lung transplantation (ICD–9–CM procedure code 33.6) and heart transplantation (ICD–9–CM procedure code 37.5) be assigned to pre-MDC. In this way, cases involving a bone marrow transplant and a heart transplant would be assigned to DRG 103 (DRG 103 would be reordered higher in the pre-MDC surgical hierarchy, as discussed in section II.B.5. of this preamble).

b. Heart Assist Devices

We continue to review data in MDC 5 (Diseases and Disorders of the Circulatory System) to determine if cases are being assigned to the most appropriate DRG based on clinical coherence and similar resource consumption. At the December 1, 1994 ICD–9–CM Coordination and Maintenance Committee meeting, we recommended creation of new codes to capture single and bi-ventricular heart assist systems. These codes, 37.65 (Implant of an external, pulsatile heart assist system) and 37.66 (Implant of an implantable, pulsatile heart assist system), were adopted for use for discharges occurring on or after October 1, 1995. However, code 37.66 was deemed investigational and was not considered a covered procedure. Effective May 5, 1997, we revised Medicare coverage of heart assist devices to allow coverage of a ventricular assist device (code 37.66) used for support of blood circulation postcardiotomy if certain conditions were met.

Due to some residual misunderstanding regarding this coverage policy, we would like to emphasize that this device was and will continue to be listed as a noncovered procedure in the Medicare Code Editor (MCE), the front-end software product in the GROUPER program that detects and reports errors in the coding of claims data. The reason that this device is listed in the MCE, in spite of the fact that its implantation is covered, is because of the stringent conditions that must be met by hospitals in order to receive payment.

In the August 29, 1997 final rule (62 FR 45973), we moved procedure code 37.66 from DRGs 110 and 111 [1] (Major Cardiovascular Procedures with and without CCs, respectively) to DRG 108 (Other Cardiothoracic Procedures). As stated in the July 31, 1998 final rule (63 FR 40956), we moved procedure code 37.66 to DRGs 104 and 105 (Cardiac Valve and Other Major Cardiothoracic Procedures with and without CCs, respectively) for FY 1999.

In the July 30, 1999 final rule (64 FR 41498), we responded to a comment suggesting that heart assist devices be assigned to DRG 103. In further consideration of this issue, we have reviewed the 100 percent FY 1999 MedPAR file containing bills through December 31, 1999, and found that there were a total of 47 implantable heart assist system procedures performed on Medicare beneficiaries. Of these cases, 13 (approximately 28 percent) were assigned to DRG 103 (Heart Transplant) and four (approximately 9 percent) were assigned to DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses), and, therefore, were paid at significantly higher rates than the remaining 30 cases. All of the procedure code 37.66 cases have extremely high charges, which is consistent with past

[1] A single title combined with two DRG numbers is used to signify pairs. Generally, the first DRG is for cases with CC and the second DRG is for cases without CC. If a third number is included, it represents cases with patients who are age 0–17. Occasionally, a pair of DRGs is split between age ≥17 and age 0–17.

analysis, and all of these cases are subject to payment as cost outliers.

Our data analysis indicates that the most cases in any one hospital is 5, while 17 hospitals performed only one heart assist system implant each. We reiterate that only heart transplant cases can be properly assigned to the transplant DRG (August 29, 1997 final rule (62 FR 45974)). Since heart assist devices are used across DRGs, many not involving a transplant, we are not proposing to assign procedure code 37.66 to DRG 103.

In addition to the review of 37.66, we also looked at procedure codes 37.62 (Implant of other heart assist system), 37.63 (Replacement and repair of heart assist system), and 37.65 (Implant of an external, pulsatile heart assist system). These cases are currently assigned to DRGs 110 and 111 (Major Cardiovascular Procedures). We believe that these procedures are similar both clinically and in terms of resource utilization to procedure code 37.66, which is already assigned to DRGs 104 and 105. Therefore, we propose to move codes 37.62, 37.63, and 37.65 from DRGs 110 and 111 to DRGs 104 and 105.

c. Platelet Inhibitors

Effective October 1, 1998, procedure code 99.20 (Injection or infusion of platelet inhibitor) was created. The use of platelet inhibitors have been shown to significantly decrease the rate of acute vessel closure, as well as the rate of cardiac complications and death. Platelet inhibitors are frequently administered to patients undergoing percutaneous transluminal coronary angioplasty (PTCA). In addition, patients admitted with unstable angina may also benefit from platelet inhibitors. This procedure code is designated as a non-OR procedure that does not affect DRG assignment (platelet inhibitors are administered either through intravenous injection or infusion).

For the past 2 years, a manufacturer of platelet inhibitors has submitted data to support its position that cases involving platelet inhibitor therapy receiving angioplasty should be reclassified from DRG 112 (Percutaneous Cardiovascular Procedures) to DRG 116 (Other Permanent Cardiac Pacemaker Implant or PTCA with Coronary Artery Stent Implant). In the July 30, 1999 final rule (64 FR 41503), we noted that we had received a new set of data from the platelet inhibitor manufacturer containing 27,673 cases from 164 hospitals in which Medicare patients underwent an angioplasty.

Included with the data were tables summarizing the results of the commenter's analysis of the data, showing that angioplasty cases receiving platelet inhibitor therapy are more expensive than those not receiving platelet inhibitors. According to the commenter, the approximate average standardized charges for the different classes of patients are as follows:

- No drug, no stent: $19,877.
- No drug, with stent: $22,968.
- Drug, no stent: $26,389.
- Drug, stent: $30,139.

Using the 100 percent FY 1999 MedPAR file that contains discharges through September 30, 1999, we performed analysis of the cases for which procedure code 99.20 was reported. There were a total of 37,222 cases spread across 123 DRGs.

The majority of the platelet inhibitor cases, 28,022 (75 percent of all platelet inhibitor cases), are *already* assigned to DRG 116. The average standardized charges for these cases are approximately $26,683, compared to approximately $25,251 for DRG 116 overall. In DRG 112, there were 4,310 platelet inhibitor cases (12 percent of all platelet inhibitor cases) assigned. The average standardized charge for these cases is approximately $22,786, compared to approximately $20,224 for DRG 112 overall. Although the platelet inhibitor therapy cases that are classified to DRG 112 do have somewhat higher charges than the average case assigned to this DRG (11 percent, or $2,563), we found several procedures in DRG 112 with average standardized charges higher than the platelet inhibitor cases. For example, there were 1,560 cases in which a single vessel PTCA or coronary atherectomy with thrombolytic agent (procedure code 36.02) was performed with an average standardized charge of approximately $25,181, and there were 4,951 cases in which a multiple vessel PTCA or coronary atherectomy was performed, with or without a thrombolytic agent (procedure code 36.05) with an average standardized charge of approximately $23,608.

We also noted that there are several procedures assigned to DRG 112 that have average standardized charges lower than the average charges for all cases in the DRG. For example, average charges for cases with procedure code 37.34 (Catheter ablation of lesion or tissues of heart) were $18,429. The following chart illustrates the variation among the average charges for DRG 112. This chart shows that the average charges for cases with procedure code 99.20 are well within the normal variation of other procedures.

DRG 112	Cases	Average standardized charges
Catheter ablation of lesion or tissues of heart (code 37.34)	6,972	$18,429
All cases within DRG 112	60,842	20,224
Injection or infusion of platelet inhibitor (code 99.20)	4,310	22,786
Multiple vessel PTCA or coronary atherectomy with or without mention of thrombolytic agent (code 36.05)	4,951	23,608
Single vessel PTCA or coronary atherectomy with mention of thrombolytic agent (code 36.02)	1,560	25,181

These examples indicate that there is always some variation in charges within a DRG. This difference in variations of charges is within the normal range of charge variations.

Clinical homogeneity within DRGs has always been a fundamental principle considered when assigning codes to appropriate DRGs. Currently, DRG 116 includes cases involving the insertion of a pacemaker as well as the insertion of coronary artery stents with PTCA. On the other hand, cases assigned to DRG 112 involve less invasive operating room and, in some cases, nonoperating room procedures.

The basis for DRG assignment has generally been the diagnosis of the patient or the procedures performed. To the extent the use of a particular technology becomes prevalent in the treatment of a particular type of case, the DRG system is designed to account for any increases or decreases in costs through recalibration. Hospitals frequently benefit from this process while efficiency-enhancing technology is being introduced. We believe that the update factors established in section 1886(b)(3)(B)(i) of the Act, combined with the potential for continuing improvements in hospital productivity, and annual recalibration of the DRG

weights, are adequate to finance appropriate care of Medicare patients.

We also received a comment from another manufacturer of platelet inhibitors whose therapy is targeted on acute coronary syndrome patients without coronary intervention. These cases are assigned to DRG 124 (Circulatory Disorders Except Acute Myocardial Infarction with Cardiac Catheterization and Complex Diagnosis) or DRG 140 (Angina Pectoris). The manufacturer's concern is that both types of cases, those performed in conjunction with coronary intervention and those without, be given an equal focus in this evaluation.

Based on our analysis, we found 410 platelet inhibitor cases (1 percent) assigned to DRG 124. This is a small percentage of cases in comparison to the overall total of 134,759 cases assigned to this DRG. The platelet inhibitor cases had an average standardized charge of approximately $17,378 compared to approximately $14,730 for DRG 124 overall. As we have illustrated above, there is always some variation in charges within a DRG and this difference is within normal variation.

There were 66 platelet inhibitor cases (0.2 percent) assigned to DRG 140. The average standardized charge for these cases is higher than the overall DRG charge, approximately $8,992 and $5,657, respectively. However, it represents a small percentage of the total (76,913) cases assigned to DRG 140.

In summary, currently 75 percent of cases where code 99.20 is present are assigned to DRG 116. The next most common DRG where these cases are assigned is DRG 112 (12 percent). Cases assigned to DRG 116 generally involve implantation of a pacemaker or artery stent, while cases assigned to DRG 112 involve percutaneous cardiovascular procedures. Our analysis found a $3,897 difference between cases involving platelet inhibitor therapy that were assigned to DRG 116 and cases assigned to DRG 112, indicating a clinical distinction between the cases grouping to the two DRGs. Finally, among platelet inhibitor therapy cases that are assigned to DRG 112, our analysis found that the average charges are well within the normal variation around the overall average charges within the DRG. Based on these findings, we do not believe it would be appropriate to assign all cases where procedure code 99.20 is present to DRG 116. Therefore, we are not proposing to change to our current policy which specifies that assignment of cases to this code does not affect the DRG assignment.

d. Extracorporeal Membrane Oxygenation

Extracorporeal Membrane Oxygenation (ECMO) is a cardiopulmonary bypass technique that provides long-term cardiopulmonary support to patients who have reversible cardiopulmonary insufficiency that has not responded to conventional management. It involves passing a patient's blood through an extracorporeal membrane oxygenator which adds oxygen and removes carbon dioxide. The oxygenated blood then is passed through a heat exchanger to warm it to body temperature prior to returning it to the patient. The process and equipment are similar to those used in open heart surgery, but are continued over prolonged periods of time. ECMO attempts to provide the patient with artificial cardiopulmonary function while his or her own cardiopulmonary functions are incapable of sustaining life.

Since ECMO involves the use of a device that sustains cardiopulmonary function while the underlying condition is being treated, it is important to identify and treat underlying conditions leading to cardiopulmonary failure if the patient is to return to normal cardiopulmonary function.

ECMO is assigned to procedure code 39.65 (Extracorporeal membrane oxygenation (ECMO)). This code is not recognized as an OR procedure within the DRG system and, therefore, does not affect payment. To evaluate the appropriateness of payment under the current DRG assignment, we have reviewed a 10-percent sample of Medicare claims in the FY 1999 MedPAR file and found only 4 cases in which ECMO was used. The charges for these cases ranged from $16,006 to $198,014. Since medical literature indicates that ECMO is predominately used on newborns and pediatric cases, this low number of claims is not surprising. Only in recent years have some hospitals started to use ECMO on adults. It is reserved for cases facing almost certain mortality.

Because ECMO is a procedure clinically similar to a heart assist device, we are proposing that procedure code 39.65 be classified as an OR procedure and be classified in DRGs 104 and 105 along with the heart assist system procedures (as discussed in section II.B.2.b. of this preamble). Those cases in which ECMO was provided, but for which the principal diagnosis is not classified to MDC 5, would then be assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis). This would be appropriate since it is possible that secondary conditions or complications may arise during hospitalization that would require the use of ECMO. The relatively high weight of DRG 468 would be appropriate for these cases.

3. MDC 15 (Newborns and Other Neonates With Conditions Originating in the Perinatal Period)

a. V05.8 (Vaccination for Disease, NEC)

DRG 390 (Neonate with Other Significant Problems) contains newborn or neonate cases with other significant problems, not assigned to DRGs 385 through 389, DRG 391, or DRG 469. In order to be classified into DRG 391 (Normal Newborn), the neonate must have a principal diagnosis as listed under DRG 391 and either no secondary diagnosis or a secondary diagnosis as listed under DRG 391. Neonates with a secondary diagnosis of V05.8 (Vaccination for disease, NEC) are currently classified to DRG 390. Although it would seem that healthy newborns who receive vaccinations and have no other problems should be classified to DRG 391, code V05.8 was not included as one of the secondary diagnoses under DRG 391, and therefore the case would not be classified as a normal newborn (DRG 391). Code V05.8 is assigned to DRG 390 as a default, since it is not included under another complicated neonate DRG or the normal newborn DRG.

Based on inquiries we have received, we reviewed the appropriateness of including diagnosis code V05.8 on the list of acceptable secondary diagnoses under DRG 390. It was pointed out that by including V05.8 on the acceptable secondary diagnosis list for DRG 390, newborns who receive vaccinations are classified as having significant health problems. The inquirers believed this incorrectly labels an otherwise healthy newborn as having a significant medical condition. Providing a vaccination to a newborn is performed to prevent the infant from contracting a disease.

We agree with the inquirers that, absent any evidence of disease, a newborn should not be considered as having a significant problem simply because a preventative vaccination was provided. Therefore, we are proposing that V05.8 be removed from the list of acceptable secondary diagnoses under DRG 390 and assigned as a secondary diagnosis under DRG 39l. In doing so, these cases would no longer be classified to DRG 390.

b. Diagnosis Code 666.02 (Third-stage Postpartum Hemorrhage, Delivered With Postpartum Complication)

Diagnosis code 666.02 is assigned to DRG 373 (Vaginal Delivery without Complicating Diagnosis). This DRG was created for uncomplicated vaginal deliveries. However, code 666.22 (Delayed and secondary postpartum hemorrhage, delivered with postpartum complication) is assigned to DRG 372 (Vaginal Delivery with Complicating Diagnoses). This means that mothers who had a delayed and secondary postpartum hemorrhage would be assigned to DRG 372, while mothers who had a third-stage postpartum hemorrhage would not be considered as a complicated delivery.

We believe a third-stage postpartum hemorrhage should be considered a complicating diagnosis and, in order to more appropriately categorize these cases, we are proposing that diagnosis code 666.02 be removed from DRG 373 and assigned as a complicating diagnosis under DRG 372.

c. Diagnosis Code 759.89 (Specified Congenital Anomalies, NEC) (Alport's Syndrome)

Alport's Syndrome (also referred to as hereditary nephritis) is an inherited disorder involving damage to the kidney, blood in the urine, and, in some cases, loss of hearing. It may also include loss of vision. Patients who are not treated early enough or who do not respond to treatment may progress to renal failure. A kidney transplant is one treatment option for these cases. As with many of the congenital anomalies, there is no unique ICD–9–CM code for this condition. Alport's Syndrome, along with many other rare and diverse congenital anomalies, is assigned to the rather nonspecific diagnosis code 759.89 (Specific congenital anomalies, NEC). Examples include William Syndrome, Brachio-Oto-Renal Syndrome, and Costello's Syndrome. Each of these is a unique hereditary disorder affecting a variety of body systems.

Patients can be diagnosed and treated for congenital anomalies throughout their lives; treatment is not restricted to the neonatal period. In our GROUPER, however, each diagnosis code is assigned to just one MDC. In this case, diagnosis code 759.89 is assigned to MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period) even though the patient may be an adult.

We have received a request from a physician concerning renal transplants for patients with Alport's Syndrome. The physician pointed out that when a patient with Alport's Syndrome is admitted for a kidney transplant, the case is assigned to DRG 390 (Neonate with Other Significant Problems). In these instances, when the principal diagnosis is code 759.89, the case is classified to MDC 15 even though the patient may no longer be a newborn. The physician believed that these cases should be assigned to DRG 302 (Kidney Transplant).

The inquirer suggested moving diagnosis code 759.89 to MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract) so that when a kidney transplant is performed, it will be assigned to DRG 302. Although this seems quite appropriate for patients with Alport's Syndrome found in diagnosis code 759.89, it does not work well for the wide variety of patients also described by this code. Many others would be inappropriately classified to MDC 11.

Alport's Syndrome cases with code 759.89 as a principal diagnosis who receive a kidney transplant are assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis). This DRG has a FY 2000 relative weight of 3.6400. Also for FY 2000, DRG 302 (Kidney Transplant) has a relative weight of 3.5669. Therefore, the payment amounts are in fact comparable.

There are several options for resolving this issue:

(1) If the case is assigned a principal diagnosis code of renal failure with Alport's Syndrome as a secondary diagnosis, the case could be assigned to DRG 302. As this option would represent a change in the sequencing of congenital anomaly codes and related complications, it would have to be evaluated and subsequently approved by the Editorial Advisory Board for *Coding Clinic for ICD–9–CM.* This Editorial Advisory Board contains representatives from the physician, coding, and hospital industry. Final decisions on coding policy issues are made by the representatives from the American Hospital Association, the American Health Information Management Association, the National Center for Health Statistics, and HCFA.

Since a change in sequencing of congenital anomaly codes and their manifestations and complications would require a change of coding policy, this issue was brought to the Editorial Advisory Board, which is currently evaluating it. A final decision on any proposed policy change would not be finalized and published in time for either this proposed rule or the final rule. Therefore, this option would not assist in immediately addressing the issue at hand.

(2) A unique ICD–9–CM diagnosis code could be created for Alport's Syndrome that could then be evaluated for possible assignment within MDC 11. This issue has been referred to the National Center for Health Statistics for consideration as a future coding modification.

One difficulty with this option is the large number of congenital anomalies and the limited number of unused codes in this section of ICD–9–CM. Each new code must be carefully evaluated for appropriateness.

(3) A third option, which was already addressed, involves moving diagnosis code 759.89 to MDC 11. The problem with this approach is that many cases would then be misassigned to MDC 11 because the congenital anomaly would not involve diseases of the kidney and urinary tract.

(4) A fourth option would be to leave the coding and DRG assignment as they currently exist. Since few cases exist, the overall impact may be minimal.

To evaluate the impact of leaving the DRG assignment as it currently exists, we examined data from a 10-percent sample of Medicare cases in the FY 1999 MedPAR file. There were 95 cases assigned to a wide range of DRGs with code 759.89 as a secondary diagnosis. There was only one case assigned to MDC 15 with a principal diagnosis of code 759.89.

We are recommending that diagnosis code 759.89 remain in MDC 15, since it encompasses such a wide variety of conditions. In addition, we are not proposing a change in the DRG assignment because the payment impact would be minimal and the cases few. We will continue to pursue the possibility of modifying the ICD–9–CM code as well as evaluating the coding rules.

4. MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasm)

Diagnosis code 273.8 (Disorders of plasma protein metabolism, NEC) is assigned to DRG 403 (Lymphoma and Nonacute Leukemia with CC) and DRG 404 (Lymphoma and Nonacute Leukemia without CC). A disorder of plasma protein metabolism does not mean one has a lymphoma with nonacute leukemia. An individual can have a disorder of plasma protein metabolism without having a lymphoma or leukemia.

We have received an inquiry on the appropriateness of including diagnosis code 273.8 in DRGs 403 and 404. The inquirer pointed out that disorders of

plasma protein metabolism are not lymphomas or leukemia. We agree that diagnosis code 273.8 is not a lymphoma or leukemia and is more closely related to DRG 413 (Other Myeloproliferative Disorders or Poorly Differentiated Neoplasm Diagnoses with CC) and DRG 414 (Other Myeloproliferative Disorders or Poorly Differentiated Neoplasm Diagnoses without CC).

We examined charge data drawn from cases assigned to diagnosis code 273.8 in a 10-percent sample of Medicare cases in the FY 1999 MedPAR file and found that the average charges for these cases were also more closely related to DRGs 413 and 414 than to DRGs 403 and 404, as demonstrated in the following chart.

DRGs 403/404 all cases in 10-percent sample			DRGs 413/414 all cases in 10-percent sample		
DRG	Count	Average charge	DRG	Count	Average charge
403	2,107	$17,617	413	387	$12,278
404	296	8,063	414	47	5,906

Code	DRG	Count	Average charge	Code	DRG	Count	Average charge
273.8	403	17	$8,573	273.8	404	3	$6,644

Therefore, we are proposing to move diagnosis code 273.8 from DRGs 403 and 404 to DRGs 413 and 414.

Diagnosis code 273.8 is also included in the following surgical DRGs that are performed on patients with lymphoma or leukemia:

- DRG 400 (Lymphoma and Leukemia with Major OR Procedure).
- DRG 401 (Lymphoma and Nonacute Leukemia with Other OR Procedure with CC).
- DRG 402 (Lymphoma and Nonacute Leukemia with Other OR Procedure without CC).

The same clinical issue would apply to these surgical DRGS performed on patients with lymphoma and leukemia. Code 273.8 should be assigned to the surgical DRGs for myeloproliferative disorders since the cases are clinically similar and, as stated before, code 273.8 is not clinically similar to lymphomas and leukemias. Therefore, we are also proposing that code 273.8 be removed from the surgical DRGs related to lymphoma and leukemia (DRGS 400, 401, and 402) and assigned to the following myeloproliferative surgical DRGS, based on the procedure performed:

- DRG 406 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Major OR Procedures with CC).
- DRG 407 (Myeloproliferative Disorders Or Poorly Differentiated Neoplasms with Major OR Procedures without CC).
- DRG 408 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other OR Procedures).

5. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. Therefore, it is necessary to have a decision rule by which these cases are assigned to a single DRG. The surgical hierarchy, an ordering of surgical classes from most to least resource intensive, performs that function. Its application ensures that cases involving multiple surgical procedures are assigned to the DRG associated with the most resource-intensive surgical class.

Because the relative resource intensity of surgical classes can shift as a function of DRG reclassification and recalibration, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications, to determine if the ordering of classes coincided with the intensity of resource utilization, as measured by the same billing data used to compute the DRG relative weights.

A surgical class can be composed of one or more DRGs. For example, in MDC 11, the surgical class ''kidney transplant'' consists of a single DRG (DRG 302) and the class ''kidney, ureter and major bladder procedures'' consists of three DRGs (DRGs 303, 304, and 305). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class involves weighting each DRG for frequency to determine the average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5. Assume also that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of ''other OR procedures'' as discussed below.

This methodology may occasionally result in a case involving multiple procedures being assigned to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER searches for the procedure in the most resource-intensive surgical class, this result is unavoidable.

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average relative weight is ordered above a surgical class with a higher average relative weight. For example, the ''other OR procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the relative weight for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other OR procedures'' class is a group of procedures that are least likely to be related to the diagnoses in the MDC but are occasionally performed on patients with these diagnoses. Therefore, these procedures should only be considered if no other procedure more closely related to the diagnoses in the MDC has been performed.

A second example occurs when the difference between the average weights for two surgical classes is very small.

We have found that small differences generally do not warrant reordering of the hierarchy since, by virtue of the hierarchy change, the relative weights are likely to shift such that the higher-ordered surgical class has a lower average weight than the class ordered below it.

Based on the preliminary recalibration of the DRGs, we are proposing to modify the surgical hierarchy as set forth below. As we stated in the September 1, 1989 final rule (54 FR 36457), we are unable to test the effects of proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights due to the unavailability of the revised GROUPER software at the time the proposed rule is prepared. Rather, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification and then determine the average charge for each DRG. These average charges then serve as our best estimate of relative resource use for each surgical class. We test the proposed surgical hierarchy changes after the revised GROUPER is received and reflect the final changes in the DRG relative weights in the final rule. Further, as discussed in section II.C of this preamble, we anticipate that the final recalibrated weights will be somewhat different from those proposed, since they will be based on more complete data. Consequently, further revision of the hierarchy, using the above principles, may be necessary in the final rule.

At this time, we are proposing to revise the surgical hierarchy for the pre-MDC DRGs, MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), and MDC 10 (Endocrine, Nutritional, and Metabolic Diseases and Disorders) as follows:

- In the pre-MDC DRGs, as we stated previously, we are proposing to move DRG 103 (Heart Transplant) from MDC 5 to pre-MDC. We are proposing to reorder DRG 103 (Heart Transplant) above DRG 483 (Tracheostomy Except for Face, Mouth, and Neck Diagnoses).
- In the pre-MDC DRGs, we are proposing to reorder DRG 481 (Bone Marrow Transplant) above DRG 495 (Lung Transplant).
- In MDC 8, we are proposing to reorder DRG 230 (Local Excision and Removal of Internal Fixation Devices of Hip and Femur) above DRG 226 (Soft Tissue Procedures with CC) and DRG 227 (Soft Tissue Procedures without CC).
- In MDC 10, we are proposing to reorder DRG 288 (OR Procedures for Obesity) above DRG 285 (Amputation of Lower Limb for Endocrine, Nutritional, and Metabolic Disorders).

6. Refinement of Complications and Comorbidities (CC) List

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered a valid CC in combination with a particular principal diagnosis. Thus, we created the CC Exclusions List. We made these changes for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative coding or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. We developed this standard list of diagnoses using physician panels to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list. At this time, we do not propose to delete any of the diagnosis codes on the CC list.

In the May 19, 1987 proposed notice (52 FR 18877) concerning changes to the DRG classification system, we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another (as subsequently corrected in the September 1, 1987 final notice (52 FR 33154)).
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for a condition should not be considered CCs for one another.
- Conditions that may not coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- The same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended only as a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be considered complications or comorbidities of another diagnosis. For that reason, and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC. (See the September 30, 1988 final rule (53 FR 38485) for the revision made for the discharges occurring in FY 1989; the September 1, 1989 final rule (54 FR 36552) for the FY 1990 revision; the September 4, 1990 final rule (55 FR 36126) for the FY 1991 revision; the August 30, 1991 final rule (56 FR 43209) for the FY 1992 revision; the September 1, 1992 final rule (57 FR 39753) for the FY 1993 revision; the September 1, 1993 final rule (58 FR 46278) for the FY 1994 revisions; the September 1, 1994 final rule (59 FR 45334) for the FY 1995 revisions; the September 1, 1995 final rule (60 FR 45782) for the FY 1996 revisions; the August 30, 1996 final rule (61 FR 46171) for the FY 1997 revisions; the August 29, 1997 final rule (62 FR 45966) for the FY 1998 revisions; and the July 31, 1998 final rule (63 FR 40954) for the FY 1999 revisions. In the July 30, 1999 final rule (64 FR 41490) we did not modify the CC Exclusions List for FY 2000 because we did not make any changes to the ICD–9–CM codes for FY 2000.

We are proposing a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2000. (See section II.B.8. below, for a discussion of ICD–9–CM changes.) These proposed changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6F and 6G in section V. of the Addendum to this proposed rule contain the proposed revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 2000. Each table shows the principal diagnoses with proposed changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6F—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 2000, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6G—Deletions from the CC

Exclusions List. Beginning with discharges on or after October 1, 2000, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $92.00 plus $6.00 shipping and handling and on microfiche for $20.50, plus $4.00 for shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161; or by calling (703) 487–4650.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, and 1999) and those in Tables 6F and 6G of this document must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 2000. (Note: There was no CC Exclusions List in FY 2000 because we did not make changes to the ICD–9–CM codes for FY 2000.)

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 17.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 18.0 of this manual, which includes the final FY 2001 DRG changes, will be available in October 2000 for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, Connecticut 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

7. Review of Procedure Codes in DRGs 468, 476, and 477

Each year, we review cases assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis), DRG 476 (Prostatic OR Procedure Unrelated to Principal Diagnosis), and DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change the procedures assigned among these DRGs.

DRGs 468, 476, and 477 are reserved for those cases in which none of the OR procedures performed is related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. DRG 476 is assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

60.0 Incision of prostate
60.12 Open biopsy of prostate
60.15 Biopsy of periprostatic tissue
60.18 Other diagnostic procedures on prostate and periprostatic tissue
60.21 Transurethral prostatectomy
60.29 Other transurethral prostatectomy
60.61 Local excision of lesion of prostate
60.69 Prostatectomy NEC
60.81 Incision of periprostatic tissue
60.82 Excision of periprostatic tissue
60.93 Repair of prostate
60.94 Control of (postoperative) hemorrhage of prostate
60.95 Transurethral balloon dilation of the prostatic urethra
60.99 Other operations on prostate

All remaining OR procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990 (55 FR 36135), August 30, 1991 (56 FR 43212), September 1, 1992 (57 FR 23625), September 1, 1993 (58 FR 46279), September 1, 1994 (59 FR 45336), September 1, 1995 (60 FR 45783), August 30, 1996 (61 FR 46173), and August 29, 1997 (62 FR 45981), we moved several other procedures from DRG 468 to 477, and some procedures from DRG 477 to 468. No procedures were moved in FY 1999, as noted in the July 31, 1998 final rule (63 FR 40962), or in FY 2000, as noted in the July 30, 1999 final rule (64 FR 41496).

a. Moving Procedure Codes From DRGs 468 or 477 to MDCs

We annually conduct a review of procedures producing assignment to DRG 468 or DRG 477 on the basis of volume, by procedure, to see if it would be appropriate to move procedure codes out of these DRGs into one of the surgical DRGs for the MDC into which the principal diagnosis falls. The data are arrayed two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC. That is, using procedure code 57.49 (Other transurethral excision or destruction of lesion or tissue of bladder) as an example, we determined that this particular code accounted for the highest number of major operative procedures (162 cases, or 9.8 percent of all cases) reported in the sample of DRG 477. In addition, we determined that procedure code 57.49 appeared in MDC 4 (Diseases and Disorders of the Respiratory System) 28 times as well as in 9 other MDCs.

Using a 10-percent sample of the FY 1999 MedPAR file, we determined that the quantity of cases in DRG 477 totaled 1,650. There were 106 instances where the major operative procedure appeared only once (6.4 percent of the time), resulting in assignment to DRG 477.

Using the same 10-percent sample of the FY 1999 MedPAR file, we reviewed DRG 468. There were a total of 3,858 cases, with one major operative code causing the DRG assignment 311 times (or 8 percent) and 230 instances where the major operative procedure appeared only once (or 6 percent of the time).

Our medical consultants then identified those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we did not identify any necessary changes in procedures under either DRG 468 or 477 and, therefore, are not proposing to move any procedures from either DRG 468 or DRG 477 to one of the surgical DRGs.

b. Reassignment of Procedures Among DRGs 468, 476, and 477

We also annually review the list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to DRGs 468, 476, and 477, to ascertain if any of those procedures should be moved from one of these DRGs to another of these DRGs based on average charges and length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment illogical. If our medical consultants were to find these shifts, we

would propose moving cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on our review this year, we are not proposing to move any procedures from DRG 468 to DRGs 476 or 477, from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476.

c. Adding Diagnosis Codes to MDCs

It has been brought to our attention that an ICD–9–CM diagnosis code should be added to DRG 482 (Tracheostomy for Face, Mouth and Neck Diagnoses) to preserve clinical coherence and homogeneity of the system. In the case of a patient who has a facial infection (diagnosis code 682.0 (Other cellulitis and abscess, Face)), the face may become extremely swollen and the patient's ability to breathe might be impaired. It might be deemed medically necessary to perform a temporary tracheostomy (procedure code 31.1) on the patient until the swelling subsides enough for the patient to once again breathe on his or her own.

The combination of diagnosis code 682.0 and procedure code 31.1 results in assignment to DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses). The absence of diagnosis code 682.0 in DRG 483 forces the GROUPER algorithm to assign the case based solely on the procedure code, without taking this diagnosis into account. Clearly this was not the intent, as diagnosis code 682.0 should be included with other face, mouth and neck diagnosis. We believe that cases such as these would appropriately be assigned to DRG 482. Therefore, we are proposing to add diagnosis code 682.0 to the list of other face, mouth and neck diagnoses already in the principal diagnosis list in DRG 482.

8. Changes to the ICD–9–CM Coding System

As described in section II.B.1 of this preamble, the ICD–9–CM is a coding system that is used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS) and HCFA, charged with maintaining and updating the ICD–9–CM system. The Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases*, while HCFA has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures.*

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, medical record administrators, health information management professionals, and other members of the public to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes for FY 2000 at public meetings held on June 4, 1998 and November 2, 1998. Even though the Committee conducted public meetings and considered approval of coding changes for FY 2000 implementation, we did not implement any changes to ICD–9–CM codes for FY 2000 because of our major efforts to ensure that all of the Medicare computer systems were compliant with the year 2000. Therefore, the code proposals presented at the public meetings held on June 4, 1998 and November 2, 1998, that (if approved) ordinarily would have been included as new codes for October 1, 1999, were held for consideration for inclusion in this proposed annual update for FY 2001.

The Committee also presented proposals for coding changes for implementation in FY 2001 at public meetings held on May 13, 1999 and November 12, 1999, and finalized the coding changes after consideration of comments received at the meetings and in writing by January 7, 2000.

Copies of the Coordination and Maintenance Committee minutes of the 1999 meetings can be obtained from the HCFA Home Page by typing http://www.hcfa.gov/medicare/icd9cm.htm. Paper copies of these minutes are no longer available and the mailing list has been discontinued. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 1100; 6525 Belcrest Road; Hyattsville, Maryland 20782. Comments may be sent by E-mail to: dfp4@cdc.gov.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; HCFA, Center for Health Plans and Providers, Purchasing Policy Group, Division of Acute Care; C4–07–07; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. Comments may be sent by E-mail to: pbrooks@hcfa.gov.

The ICD–9–CM code changes that have been approved will become effective October 1, 2000. The new ICD–9–CM codes are listed, along with their proposed DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in section VI. of the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. Therefore, we are soliciting comments only on the proposed DRG classification of these new codes.

Further, the Committee has approved the expansion of certain ICD–9–CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes or other codes, or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2000. For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A (New Diagnosis Codes). There were no procedure codes that were replaced by expanded codes or other codes, or were deleted. Revisions to diagnosis code titles are in Table 6D (Revised Diagnosis Code Titles), which also include the proposed DRG assignments

for these revised codes. Revisions to procedure code titles are in Table 6E (Revised Procedure Codes Titles).

9. Other Issues

a. Immunotherapy

Effective October 1, 1994, procedure code 99.28 (Injection or infusion of biologic response modifier (BRM) as an antineoplastic agent) was created and designated as a non-OR procedure that does not affect DRG assignment. This cancer treatment involving biological response modifiers is also known as BRM therapy or immunotherapy.

In response to a comment on the May 7, 1999 proposed rule, for the FY 2000 final rule we performed analysis of cases for which procedure code 99.28 was reported using the 100 percent FY 1998 MedPAR file. The commenter requested that we create a new DRG for BRM therapy or assign cases in which BRM therapy is performed to an existing DRG with a high relative weight. The commenter suggested that DRG 403 (Lymphoma and Nonacute Leukemia with CC) would be an appropriate DRG.

Based on the commenter's request, we examined cases only for hospitals that use the particular drug manufactured by the commenter. We concluded that due to the variation of charges across the cases and the limited number of cases distributed across 19 different DRGs, it would be inappropriate to classify these cases to a single DRG. For example, it would be inappropriate to classify these cases into DRG 403 because only a few cases were coded with a principal diagnosis assigned to MDC 17 (Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasm), the MDC that includes DRG 403. We stated in the July 30, 1999 final rule (64 FR 41497) that we would perform a full analysis of immunotherapy cases using the FY 1999 MedPAR data to determine if changes are needed.

Using 100 percent of the data in the FY 1999 MedPAR file, we performed an analysis of all cases for which procedure code 99.28 was reported. We identified 1,179 cases in 136 DRGs in 22 MDCs. No more than 141 cases were assigned to any one particular DRG.

Of the 1,179 cases, 141 cases (approximately 12 percent) were assigned to DRG 403 in MDC 17. We found approximately one-half of these cases had other procedures performed in addition to receiving immunotherapy, such as chemotherapy, bone marrow biopsy, insertion of totally implantable vascular access device, thoracentesis, or percutaneous abdominal drainage, which may account for the increased charges. There were 123 immunotherapy cases assigned to DRG 82 (Respiratory Neoplasms) in MDC 4 (Diseases and Disorders of the Respiratory System). We noted that, in some cases, in addition to immunotherapy, other procedures were performed, such as insertion of an intercostal catheter for drainage, thoracentesis, or chemotherapy.

There were 84 cases assigned to DRG 416 (Septicemia, Age >17) in MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)). The principal diagnosis for this DRG is septicemia and, in addition to receiving treatment for septicemia, immunotherapy was also given. There were 79 cases assigned to DRG 410 (Chemotherapy without Acute Leukemia as Secondary Diagnosis) in MDC 17.

The cost of immunotherapy is averaged into the weight for these DRGS and, based on our analysis, we do not believe a reclassification of these cases is warranted. Due to the limited number of cases that were distributed throughout 136 DRGs in 22 MDCs and the variation of charges, we concluded that it would be inappropriate to classify these cases into a single DRG.

Although there were 141 cases assigned to DRG 403, it would be inappropriate to place all immunotherapy cases, regardless of diagnosis, into a DRG that is designated for lymphoma and nonacute leukemia. We establish DRGs based on clinical coherence and resource utilization. Each DRG encompasses a variety of cases, reflecting a range of services and a range of resources. Generally, then, each DRG reflects some higher cost cases and some lower cost cases. To the extent a new technology is extremely costly relative to the cases reflected in the DRG relative weight, the hospital might qualify for outlier payments, that is, additional payments over and above the standard prospective payment rate. We have not received any comments from hospitals regarding payment for immunotherapy cases.

b. Pancreas Transplant

Effective July 1, 1999, Medicare covers whole organ pancreas transplantation if the transplantation is performed simultaneously with or after a kidney transplant (procedure codes 55.69, Other kidney transplantation, and V42.0, Organ or tissue replaced by transplant, Kidney) (Transmittal No. 115, April 1999). We note that when we published the notification of this coverage in the July 30, 1999 final rule (64 FR 41497), we inadvertently made an error in announcing the covered codes. We cited the incorrect codes for pancreas transplantation as procedure code 52.80 (Pancreatic transplant, not otherwise specified) and 52.83 (Heterotransplant of pancreas). The correct procedure codes for pancreas transplantation are 52.80 (Pancreatic transplant, not otherwise specified) and 52.82 (Homotransplant of pancreas). We will revise the Coverage Issues Manual to reflect this correction.

Pancreas transplantation is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness. Pancreas transplantation for diabetic patients who have not experienced end-stage renal failure secondary to diabetes is excluded from coverage. Medicare also excludes coverage of transplantation of partial pancreatic tissue or islet cells.

In the July 30, 1999 final rule (64 FR 41497), we indicated that we planned to review discharge data to determine whether a new DRG should be created, or existing DRGs modified, to further classify pancreas transplantation in combination with kidney transplantation.

Under the current DRG classification, if a kidney transplant and a pancreas transplant are performed simultaneously on a patient with chronic renal failure secondary to diabetes with renal manifestations (diagnosis codes 250.40 through 250.43), the case is assigned to DRG 302 (Kidney Transplant) in MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract). If a pancreas transplant is performed following a kidney transplant (that is, during a different hospital admission) on a patient with chronic renal failure secondary to diabetes with renal manifestations, the case is assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis). This is because pancreas transplant is not assigned to MDC 11, the MDC to which a principal diagnosis of chronic renal failure secondary to diabetes is assigned.

Using 100 percent of the data in the FY 1999 MedPAR file (which contains hospital bills through December 31, 1999), we performed an analysis of the cases for which procedure codes 52.80 and 52.83 were reported. We identified a total of 79 cases in 8 DRGs, in 3 MDCs, and in 1 pre-MDC. Of the 79 cases identified, 49 cases were assigned to DRG 302, 14 cases were assigned to DRG 468, and 8 cases were assigned to DRG 191 (Pancreas, Liver and Shunt

Procedures with CC). The additional 8 cases were distributed over 5 other assorted DRGs, and due to their disparity, were not considered in our evaluation.

We examined our data to determine whether we should propose a new kidney and pancreas transplant DRG at this time. We identified 49 such dual transplant cases in the FY 1999 MedPAR file. We do not believe this is a sufficient sample size to warrant the creation of a new DRG. Furthermore, we would note that nearly half of these cases occurred at a hospital in Maryland, which is not paid under the prospective payment system. The rest of the cases are spread across multiple hospitals, with no single hospital having more than 5 cases in the FY 1999 MedPAR.

C. Recalibration of DRG Weights.

We are proposing to use the same basic methodology for the FY 2001 recalibration as we did for FY 2000 (July 30, 1999 final rule (64 FR 41498)). That is, we would recalibrate the weights based on charge data for Medicare discharges. However, we propose to use the most current charge information available, the FY 1999 MedPAR file. (For the FY 2000 recalibration, we used the FY 1998 MedPAR file.) The MedPAR file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills.

The proposed recalibrated DRG relative weights are constructed from FY 1999 MedPAR data (discharges occurring between October 1, 1998 and September 30, 1999), based on bills received by HCFA through December 31, 1999, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1999 MedPAR file includes data for approximately 11,059,625 Medicare discharges.

The methodology used to calculate the proposed DRG relative weights from the FY 1999 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the proposed DRG classification revisions discussed in section II.B of this preamble. As noted in section II.B.5, due to the unavailability of the revised GROUPER software, we simulated most major classification changes to approximate the placement of cases under the proposed reclassification. However, there are some changes that cannot be modeled.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers, using the same criteria used in computing the current weights. That is, all cases that are outside of 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG are eliminated.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight. A transfer case is counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, transfer cases paid under the transfer methodology equal to half of what the case would receive as a nontransfer would be counted as 0.5 of a total case.
- We established the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) in a manner consistent with the methodology for all other DRGs except that the transplant cases that were used to establish the weights were limited to those Medicare-approved heart, heart-lung, liver, and lung transplant centers that have cases in the FY 1999 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from HCFA as transplant centers.)
- Acquisition costs for kidney, heart, heart-lung, liver, and lung transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant); DRG 480 (Liver Transplant); and DRG 495 (Lung Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We propose to use that same case threshold in recalibrating the DRG weights for FY 2001. Using the FY 1999 MedPAR data set, there are 40 DRGs that contain fewer than 10 cases. We computed the weights for these 40 low-volume DRGs by adjusting the FY 2000 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

The weights developed according to the methodology described above, using the proposed DRG classification changes, result in an average case weight that is different from the average case weight before recalibration. Therefore, the new weights are normalized by an adjustment factor (1.45431) so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the prospective payment system.

Section 1886(d)(4)(C)(iii) of the Act requires that, beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as we have done in past years and as discussed in section II.A.4.b. of the Addendum to this proposed rule, we are proposing to make a budget neutrality adjustment to assure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

III. Proposed Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of Metropolitan

Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by the Office of Management and Budget (OMB). The OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprising two or more PMSAs (identified by their separate economic and social character). For purposes of the hospital wage index, we use the PMSAs rather than CMSAs since they allow a more precise breakdown of labor costs. If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA. Rural areas are areas outside a designated MSA, PMSA, or NECMA. For purposes of the wage index, we combine all of the rural counties in a State to calculate a rural wage index for that State.

We note that effective April 1, 1990, the term Metropolitan Area (MA) replaced the term MSA (which had been used since June 30, 1983) to describe the set of metropolitan areas consisting of MSAs, PMSAs, and CMSAs. The terminology was changed by OMB in the March 30, 1990 **Federal Register** to distinguish between the individual metropolitan areas known as MSAs and the set of all metropolitan areas (MSAs, PMSAs, and CMSAs) (55 FR 12154). For purposes of the prospective payment system, we will continue to refer to these areas as MSAs.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey should measure, to the extent feasible, the earnings and paid hours of employment by occupational category, and must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. As discussed below in section III.F of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index.

B. FY 2001 Wage Index Update

The proposed FY 2001 wage index values in section VI of the Addendum to this proposed rule (effective for hospital discharges occurring on or after October 1, 2000 and before October 1, 2001) are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1997 (the FY 2000 wage index was based on FY 1996 wage data).

The proposed FY 2001 wage index includes the following categories of data associated with costs paid under the hospital inpatient prospective payment system (as well as outpatient costs), which were also included in the FY 2000 wage index:

- Salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Certain contract labor costs and hours.
- Wage-related costs.

Consistent with the wage index methodology for FY 2000, the proposed wage index for FY 2001 also continues to exclude the direct and overhead salaries and hours for services not paid through the inpatient prospective payment system such as skilled nursing facility services, home health services, or other subprovider components that are not subject to the prospective payment system.

We calculate a separate Puerto Rico-specific wage index and apply it to the Puerto Rico standardized amount. (See 62 FR 45984 and 46041.) This wage index is based solely on Puerto Rico's data. Finally, section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State.

C. FY 2001 Wage Index Proposal

Because it is used to adjust payments to hospitals under the prospective payment system, the hospital wage index should, to the extent possible, reflect the wage costs associated with the areas of the hospital included under the hospital inpatient prospective payment system. In response to concerns within the hospital community related to the removal from the wage index calculation costs related to graduate medical education (GME) (teaching physicians and residents), and certified registered nurse anesthetists (CRNAs), which are paid by Medicare separately from the prospective payment system, the American Hospital Association (AHA) convened a workgroup to develop a consensus recommendation on this issue. The workgroup recommended that costs related to GME and CRNAs be phased out of the wage index calculation over a 5-year period. Based upon our analysis of hospitals' FY 1996 wage data, and consistent with the AHA workgroup's recommendation, we specified in the July 30, 1999 final rule (64 FR 41505) that we would phase-out these costs from the calculation of the wage index over a 5-year period, beginning in FY 2000. In keeping with the decision to phase-out costs related to GME and CRNAs, the proposed FY 2001 wage index is based on a blend of 60 percent of an average hourly wage including these costs, and 40 percent of an average hourly wage excluding these costs.

1. Teaching Physician Costs and Hours Survey

As discussed in the July 30, 1999 final rule, because the FY 1996 cost reporting data did not separate teaching physician costs from other physician Part A costs, we instructed our fiscal intermediaries to survey teaching hospitals to collect data on teaching physician costs and hours payable under the per resident amounts (§ 413.86) and reported on Worksheet A, Line 23 of the hospitals' cost report.

The FY 1997 cost reports also do not separately report teaching physician costs. Therefore, we once again conducted a special survey to collect data on these costs. (For the FY 1998 cost reports, we have revised the Worksheet S–3, Part II so that hospitals can separately report teaching physician Part A costs. Therefore, after this year, it will no longer be necessary for us to conduct this special survey.)

The survey data collected as of mid-January 2000 were included in the preliminary public use data file made available on the Internet in February 2000 at HCFA's home page (http://www.hcfa.gov). At that time, we had received teaching physician data for 459 out of 770 teaching hospitals reporting physician Part A costs on their Worksheet S–3, Part II. Also, in some cases, intermediaries reported that teaching hospitals did not incur teaching physician costs. In early January 2000, we instructed intermediaries to review the survey data for consistency with the Supplemental Worksheet A–8–2 of the hospitals' cost reports. Supplemental Worksheet A–8–2 is used to apply the reasonable compensation equivalency limits to the costs of provider-based physicians, itemizing these costs by the corresponding line number on Worksheet A.

When we notified the hospitals, through our fiscal intermediaries, that they could review the survey data on the Internet, we also notified hospitals that requests for changes to the teaching survey data must be submitted by March 6, 2000. We instructed fiscal intermediaries to review the requests for changes received from hospitals and submit necessary data revisions to HCFA by April 3, 2000.

We removed from the wage data the physician Part A teaching costs and hours reported on the survey form for every hospital that completed the survey. These data had been verified by the fiscal intermediary before submission to HCFA. We have identified 42 teaching hospitals in our database that reported physician Part A costs on Line 4 of their Worksheet S–3 and teaching-related costs on Line 23 of Worksheet A, Column 1, but for which we do not have teaching physician costs from the survey because the hospitals failed to complete the survey. As we did in the case of such hospitals in calculating the FY 2000 wage index, for purposes of calculating the FY 2001 wage index, we propose to subtract the costs reported on Line 23 of the Worksheet A, Column 1 (GME Other Program Costs) from Line 1 of the Worksheet S–3. These costs (from Line 23, Column 1 of Worksheet A) are included in Line 1 of the Worksheet S–3, which is the sum of Column 1, Worksheet A. They also represent costs for which the hospital is paid through the per resident amount under the direct GME payment. To determine the hours to be removed, the costs reported on Line 23 of the Worksheet A, Column 1 would be divided by the national average hourly wage for teaching physicians based upon the survey of $65.62.

For the FY 2000 wage index, the AHA workgroup recommended that, if reliable teaching physician data were not available for removing teaching costs from hospitals' total physician Part A costs, HCFA should remove 80 percent of the costs and hours reported by hospitals attributable to physicians' Part A services. In calculating the FY 2000 wage index, if we did not receive survey data for a teaching hospital, we removed 80 percent of the hospital's reported total physician Part A costs and hours from the calculation. For the FY 2001 wage index, we are proposing a different approach. In some instances, fiscal intermediaries have verified that teaching hospitals do not have teaching physician costs; for these hospitals, it is not necessary to adjust the hospitals' physician Part A costs. We are actively conferring with the fiscal intermediaries to distinguish teaching hospitals that do not have teaching physician costs from teaching hospitals that have not identified the portion of their physician Part A costs associated with teaching physicians (that is, hospitals that did not complete the teaching survey and did not report teaching-related costs on Worksheet A, Line 23). We propose to remove 100 percent of the physician Part A costs and hours (reported on Worksheet S–3, Lines 4, 10, 12, and 18) in the FY 2001 wage index calculation for those hospitals where the fiscal intermediary verifies that the hospital has otherwise unidentified teaching physician costs included in physician Part A costs and hours.

It should be noted that Line 23 of Worksheet A, Column 1, flows directly into hospitals' total salaries on Worksheet S–3, Part II. Line 23 contains GME costs not directly attributable to residents' salaries or fringe benefits. Therefore, these costs tend to be costs associated with teaching physicians. To the extent a hospital fails to separately identify the proportion of its Line 23 Worksheet A costs associated with teaching physicians, we believe it is reasonable to remove all of these costs under the presumption that they are all associated with teaching physicians.

Thus, for the proposed wage index, we are either using the data submitted on the teaching physician survey or, in the absence of such data, removing the amount reported on Line 23 of Worksheet A, Column 1 or removing 100 percent of physician Part A costs reported on Worksheet S–3.

2. Nurse Practitioner and Clinical Nurse Specialist Costs

The current wage index includes salaries and wage-related costs for nurse practitioners (NPs) and clinical nurse specialists (CNSs) who, similar to physician assistants and CRNAs (unless at hospitals under the rural pass-through exception for CRNAs), are paid under the physician fee schedule. Over the past year, we have received several inquiries from hospitals and fiscal intermediaries regarding NP costs and how they should be handled for purposes of the hospital wage index. Because Medicare generally pays for NP and CNS costs under Part B outside the hospital prospective payment system, removing NP and CNS Part B costs from the wage index calculation would be consistent with our general policy to exclude, to the extent possible, costs that are not paid through the hospital prospective payment system. Because NP and CNS costs are not separately reported on the Worksheet S–3 for FYs 1997, 1998, and 1999, the FY 2000 Worksheet S–3 and cost reporting instructions will be revised to allow for separate reporting of NP and CNS Part A and Part B costs. We will exclude the Part B costs beginning with the FY 2004 wage index. These services are pervasive in both rural and urban settings. As such, we believe there will be no significant overall impact resulting from the removal of Part B costs for NPs and CNSs.

3. Severance and Bonus Pay Costs

On October 6, 1999, we issued a memorandum to hospitals and intermediaries regarding our policy on treatment of severance and bonus pay costs in developing the wage index, effective beginning with the FY 2001 wage index. (The hospital cost report instructions also will be amended to reflect our policy on these costs.) We stated that severance pay costs may be included on Worksheet S–3 as salaries on Part II, Line 1, only if the associated hours are included. If the hospital has no accounting of the hours, or if the costs are not based on hours, the severance pay costs may not be included in the wage index. On the other hand, bonus pay costs may be included in the cost report on Line 1 of Worksheet S–3 with no corresponding hours. Due to the inquiries we continue to receive from hospitals regarding the inclusion of severance pay costs on cost reports, we are clarifying our policy in this proposed rule.

Hospitals vary in their accounting of severance pay costs. Some hospitals base the amounts to be paid on hours, for example, 80 hours worth of pay. Others do not; for example, a 15-year employee may be offered a $25,000 buyout package. Some hospitals record associated hours; others do not. The Wage Index Workgroup has suggested that we not include any severance pay costs in the wage index calculation, that these costs are for terminated employees, and, therefore, they should be considered an administrative rather than a salary expense.

Severance pay costs can be substantial amounts, particularly in periods of downsizing. We believe that, if severance pay costs are included with no associated hours, the wage index, which is a relative measure of wage costs across labor market areas, would be distorted.

Severance pay costs are included in the proposed FY 2001 wage index as a salary cost to the extent that associated hours are also reported. However, we are soliciting public comments on this issue.

4. Health Insurance and Health-Related Costs

In the September 1, 1994 final rule (59 FR 45356), we stated that health insurance, purchased or self-insurance, is a core wage-related cost. Over the past year, we have received several inquiries from hospitals and hospital associations requesting that we define ''purchased health insurance costs.'' In response, in

this proposed rule, we are clarifying that, for wage index purposes, we define ''purchased health insurance costs'' as the premiums and administrative costs a hospital pays on behalf of its employees for health insurance coverage. ''Self-insurance'' includes the hospital's costs (not charges) for covered services delivered to its employees, less any amounts paid by the employees, and less the personnel costs for hospital staff who delivered the services (these costs are already included in the wage index). For purchased health insurance and self-health insurance, the included costs must be for services covered in a health insurance plan.

Also, in the September 1, 1994 final rule (59 FR 45357), we addressed a comment about the inclusion of health-related costs in the calculation of the wage index. Such health-related costs include employee physical examinations, flu shots, and clinic visits, and other services that are not covered by employees' health insurance plans but are provided at no cost or at discounted rates to employees of the hospital. We are clarifying that the costs for these services may be included as an ''other'' wage-related cost if (among other criteria), when all such health-related costs are combined, the total of such costs is greater than 1 percent of the hospital's total salaries (less excluded area salaries). As discussed in the September 1, 1994 final rule (59 FR 45357), a cost may be allowable as an ''other wage-related cost'' if it meets certain criteria. Under one criterion, the wage-related cost must be greater than 1 percent of total salaries (less excluded area salaries). For purposes of applying this 1-percent test with respect to the health-related costs at issue here, we look at the combined total of the health-related costs (not charges) for services delivered to its employees, less any amounts employees paid, and less the personnel costs for hospital staff who delivered the services (as these costs are already included in the wage index).

5. Elimination of Wage Costs Associated With Rural Health Clinics and Federally Qualified Health Centers

The current hospital wage index includes the salaries and wage-related costs of hospital-based rural health clinics (RHCs) and federally qualified health centers (FQHCs). However, Medicare pays for these costs outside the hospital inpatient prospective payment system. Effective January 1, 1998, under section 1833(f) of the Act, as amended by section 4205 of Public Law 105–33, Medicare pays both hospital-based and freestanding RHCs and FQHCs on a cost-per-visit basis. Medicare cost reporting forms for RHCs and FQHCs were revised to reflect this legislative change, beginning with cost reporting periods ending on or after September 30, 1998 (the FY 1998 cost report). Other cost-reimbursed outpatient departments, such as ambulatory surgical centers, community mental health centers, and comprehensive outpatient rehabilitation facilities, are presently excluded from the wage index. Therefore, consistent with our wage index refinements that exclude, to the extent possible, costs associated with services not paid under the hospital inpatient prospective payment system, we believe it would be appropriate to exclude all salary costs associated with RHCs and FQHCs from the wage index calculation if we had feasible, reliable data for such exclusion.

Because RHC and FQHC costs are not separately reported on the Worksheet S–3 for FYs 1997, 1998, and 1999, we cannot exclude these costs from the FY 2001, FY 2002, or FY 2003 wage indexes. Therefore, we will revise the FY 2000 Worksheet S–3 to begin providing for the separate reporting of RHC and FQHC salaries, wage-related costs, and hours. We will evaluate the wage data for RHCs and FQHCs in developing the FY 2004 wage index.

D. Verification of Wage Data From the Medicare Cost Report

The data for the proposed FY 2001 wage index were obtained from Worksheet S–3, Parts II and III of the FY 1997 Medicare cost reports. The data file used to construct the proposed wage index includes FY 1997 data submitted to HCFA as of mid-February 2000. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. Some unresolved data elements are included in the calculation of the proposed FY 2001 wage index pending their resolution before calculation of the final FY 2001 wage index. We have instructed the intermediaries to complete their verification of questionable data elements and to transmit any changes to the wage data (through HCRIS) no later than April 3, 2000. We expect that all unresolved data elements will be resolved by that date. The revised data will be reflected in the final rule.

Also, as part of our editing process, we removed data for 19 hospitals that failed edits. For two of these hospitals, we were unable to obtain sufficient documentation to verify or revise the data because the hospitals are no longer participating in the Medicare program or are in bankruptcy status. Four hospitals had negative average hourly wages after allocating overhead to their excluded areas and, therefore, were removed from the calculation. The data from the remaining 13 hospitals also failed the edits and were removed. The data for these hospitals will be included in the final wage index if we receive corrected data that pass our edits. As a result, the proposed FY 2001 wage index is calculated based on FY 1997 wage data for 4,926 hospitals.

E. Computation of the Proposed FY 2001 Wage Index

The method used to compute the proposed FY 2001 wage index is as follows:

Step 1—As noted above, we are proposing to base the FY 2001 wage index on wage data reported on the FY 1997 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1996 and before October 1, 1997. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1996 and reported a cost reporting period exceeding 52 weeks. These data were included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1997 data. We note that, if a hospital had more than one cost reporting period beginning during FY 1997 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 1996 and before October 1, 1997), we included wage data from only one of the cost reporting periods, the longest, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the latest period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage is a blend of 60 percent of the hospital's average hourly wage including all GME and CRNA costs, and 40 percent of the hospital's average hourly wage after eliminating all GME and CRNA costs.

In calculating a hospital's average salaries plus wage-related costs,

including all GME and CRNA costs, we subtracted from Line 1 (total salaries) the Part B salaries reported on Lines 3 and 5, home office salaries reported on Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to skilled nursing facility services, home health services, and other subprovider components not subject to the prospective payment system). We also subtracted from Line 1 the salaries for which no hours were reported on Lines 2, 4, and 6. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, and physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, 16, 18, and 20).

We note that contract labor and home office salaries for which no corresponding hours are reported were not included. In addition, wage-related costs for specific categories of employees (Lines 16, 18, and 20) are excluded if no corresponding salaries are reported for those employees (Lines 2, 4, and 6, respectively).

We then calculated a hospital's salaries plus wage-related costs by subtracting from total salaries the salaries plus wage-related costs for teaching physicians, Part A CRNAs (Lines 2 and 16), and residents (Lines 6 and 20).

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we computed total hours using the same methods as described for salaries in Step 2.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs. First, we determined the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 3, 5, and 7 and Part III, Line 13 of Worksheet S–3). We then computed the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Finally, we subtracted the computed overhead salaries and hours associated with excluded areas from the total salaries and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1996 through April 15, 1998 for private industry hospital workers from the Bureau of Labor Statistics' *Compensation and Working Conditions.* We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/96	11/15/96	1.02848
11/14/96	12/15/96	1.02748
12/14/96	01/15/97	1.02641
01/14/97	02/15/97	1.02521
02/14/97	03/15/97	1.02387
03/14/97	04/15/97	1.02236
04/14/97	05/15/97	1.02068
05/14/97	06/15/97	1.01883
06/14/97	07/15/97	1.01695
07/14/97	08/15/97	1.01520
08/14/97	09/15/97	1.01357
09/14/97	10/15/97	1.01182
10/14/97	11/15/97	1.00966
11/14/97	12/15/97	1.00712
12/14/97	01/15/98	1.00451
01/14/98	02/15/98	1.00213
02/14/98	03/15/98	1.00000
03/14/98	04/15/98	0.99798

For example, the midpoint of a cost reporting period beginning January 1, 1997 and ending December 31, 1997 is June 30, 1997. An adjustment factor of 1.01695 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 1997 and covers a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B) or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted salaries plus wage-related costs obtained in Step 5 (with and without GME and CRNA costs) for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divided the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Because the proposed FY 2001 wage index is based on a blend of average hourly wages, we then added 60 percent of the average hourly wage calculated without removing GME and CRNA costs, and 40 percent of the average hourly wage calculated with these costs excluded.

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage (using the same blending methodology described in Step 7). Using the data as described above, the national average hourly wage is $21.6988.

Step 9—For each urban or rural labor market area, we calculated the hospital wage index value by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $9.9667 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to assure that aggregate

prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2001, this change affects 241 hospitals in 41 MSAs. The MSAs affected by this provision are identified in Table 4A by a footnote.

F. Revisions to the Wage Index Based on Hospital Redesignation

Under section 1886(d)(8)(B) of the Act, hospitals in certain rural counties adjacent to one or more MSAs are considered to be located in one of the adjacent MSAs if certain standards are met. Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system.

Under section 152 of Public Law 106–113, hospitals in certain counties are deemed to be located in specified areas for purposes of payment under the hospital inpatient prospective payment system, for discharges occurring on or after October 1, 2000. For payment purposes, these hospitals are to be treated as though they were reclassified for purposes of both the standardized amount and the wage index. We are proposing to calculate FY 2001 wage indexes for hospitals in the affected counties as if they were reclassified to the specified area.

For purposes of making payments under section 1886(d) of the Act for FY 2001, section 152 provides the following:

- Iredell County, North Carolina is deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina MSA;
- Orange County, New York is deemed to be located in the New York, New York MSA;
- Lake County, Indiana and Lee County, Illinois are deemed to be located in the Chicago, Illinois MSA;
- Hamilton-Middletown, Ohio is deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana MSA;
- Brazoria County, Texas is deemed to be located in the Houston, Texas MSA;
- Chittenden County, Vermont is deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire MSA.

Section 152 also requires that these reclassifications be treated for FY 2001 as though they are reclassification decisions by the MGCRB. Therefore, the proposed wage indexes for the areas to which these hospitals are reclassifying, as well as the wage indexes for the areas in which they are located, are subject to all of the normal rules for calculating wage indexes for hospitals affected by reclassification decisions by the MGCRB, as described below.

In addition, we would note that the reclassifications enacted by section 152 pertain only to the hospitals located in the specified counties, not to hospitals in other counties within the MSA or hospitals reclassified into the MSA by the MGCRB.

Under section 154 of Public Law 106–113, the Allentown-Bethlehem-Easton, Pennsylvania MSA wage index will be calculated including the wage data for Lehigh Valley Hospital. Section 154 states that, for FY 2001, ''[n]otwithstanding any other provision of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), in calculating and applying the wage indices under that section for discharges occurring during fiscal year 2001, Lehigh Valley Hospital shall be treated as being classified in the Allentown-Bethlehem-Easton Metropolitan Statistical Area.'' This statutory language directs us to include Lehigh Valley Hospital's wage data in the wage index calculation for the Allentown-Bethlehem-Easton MSA for FY 2000 and FY 2001, and to apply the Allentown-Bethlehem-Easton MSA wage index to Lehigh Valley Hospital for discharges occurring during FY 2001.

Section 1886(d)(8)(B) of the Act established that a hospital located in a rural county adjacent to one or more urban areas is treated as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an MSA (or NECMAs), if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs. Through FY 2000, hospitals are required to use standards published in the **Federal Register** on January 3, 1980, by the Office of Management and Budget. For FY 2000, there were 26 hospitals affected by this provision.

Section 402 of Public Law 106–113 amended section 1886(d)(8)(B) of the Act to allow hospitals to elect to use the standards published in the **Federal Register** on January 3, 1980 (1980 decennial census data) or March 30, 1990 (1990 decennial census data) during FY 2001 and FY 2002. As of FY 2003, hospitals will be required to use the standards published in the **Federal Register** by the Director of the Office of Management and Budget based on the most recent available decennial population data.

We are in the process of working with the Office of Management and Budget to identify the hospitals that would be affected by this amendment. We refer the reader to the September 30, 1988 final rule (53 FR 38499) for a complete discussion of our approach to identify the outlying counties using the standards published in the January 3, 1980 **Federal Register**.

The methodology for determining the wage index values for redesignated hospitals is applied jointly to the hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act and those hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. Therefore, as provided in section 1886(d)(8)(C) of the Act, the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the redesignated hospitals are subject to that combined wage index value.
- If including the wage data for the redesignated hospitals increases the wage index value for the area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value.
- The wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.
- Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred.
- Rural areas whose wage index values increase as a result of excluding the wage data for the hospitals that have been redesignated to another area have

their wage index values calculated exclusive of the wage data of the redesignated hospitals.

• The wage index value for an urban area is calculated exclusive of the wage data for hospitals that have been reclassified to another area. However, geographic reclassification may not reduce the wage index value for an urban area below the statewide rural wage index value.

We note that, except for those rural areas in which redesignation would reduce the rural wage index value, the wage index value for each area is computed exclusive of the wage data for hospitals that have been redesignated from the area for purposes of their wage index. As a result, several urban areas listed in Table 4A have no hospitals remaining in the area. This is because all the hospitals originally in these urban areas have been reclassified to another area by the MGCRB. These areas with no remaining hospitals receive the prereclassified wage index value. The prereclassified wage index value will apply as long as the area remains empty.

The proposed wage index values for FY 2001 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this proposed rule. Hospitals that are redesignated should use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located. When the wage index value of the area to which a hospital is redesignated is lower than the wage index value for the rural areas of the State in which the hospital is located, the redesignated hospital receives the higher wage index value; that is, the wage index value for the rural areas of the State in which it is located, rather than the wage index value otherwise applicable to the redesignated hospitals.

Tables 4D and 4E list the average hourly wage for each labor market area, before the redesignation of hospitals, based on the FY 1997 wage data. In addition, Table 3C in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital based on the preliminary FY 1997 data as of February 25, 2000 (reflecting the phase-out of GME and CRNA wages as described at section III.C of this preamble). The MGCRB will use the average hourly wage published in the final rule to evaluate a hospital's application for reclassification for FY 2002 (unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(w)(2)). We note that in adjudicating these wage index reclassifications the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 2001 wage index.

At the time this proposed wage index was constructed, the MGCRB had completed its review of FY 2001 reclassification requests. The proposed FY 2001 wage index values incorporate all 586 hospitals redesignated for purposes of the wage index (hospitals redesignated under section 1886(d)(8)(B) or 1886(d)(10) of the Act, and section 152 Public Law 106–113) for FY 2001. The final number of reclassifications may vary because some MGCRB decisions are still under review by the Administrator and because some hospitals may withdraw their requests for reclassification.

Any changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process will be incorporated into the wage index values published in the final rule following this proposed rule. The changes may affect not only the wage index value for specific geographic areas, but also the wage index value redesignated hospitals receive; that is, whether they receive the wage index value for the area to which they are redesignated, or a wage index value that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index value for the area from which the hospitals are redesignated may be affected.

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of this proposed rule in the **Federal Register**. The request for withdrawal of an application for reclassification that would be effective in FY 2001 must be received by the MGCRB by June 19, 2000. A hospital that requests to withdraw its application may not later request that the MGCRB decision be reinstated.

G. Requests for Wage Data Corrections

To allow hospitals time to evaluate the wage data used to construct the proposed FY 2001 hospital wage index, we made available to the public a data file containing the FY 1997 hospital wage data. As stated in section II.D of this preamble, the data file used to construct the proposed wage index includes FY 1997 data submitted to HCFA as of mid-February 2000. In a memorandum dated January 28, 2000, we instructed all Medicare intermediaries to inform the prospective payment hospitals that they service of the availability of the wage data file and the process and timeframe for requesting revisions. The wage data file was made available on February 7, 2000 through the Internet at HCFA's home page (http://www.hcfa.gov). We also instructed the intermediaries to advise hospitals of the availability of these data either through their representative hospital organizations or directly from HCFA. Additional details on ordering this data file are discussed in section IX.A of this preamble, ''Requests for Data from the Public.''

In addition, Table 3C in the Addendum to this proposed rule contains each hospital's adjusted average hourly wage used to construct the proposed wage index values. It should be noted that the hospital average hourly wages shown in Table 3C may not reflect any changes made to a hospital's data after February 7, 2000. Changes approved by a hospital's fiscal intermediary and forwarded to HCFA by April 3, 2000 will be reflected on the final public use wage data file scheduled to be made available on May 5, 2000.

We believe hospitals have sufficient time to ensure the accuracy of their FY 1997 wage data. Moreover, the ultimate responsibility for accurately completing the cost report rests with the hospital, which must attest to the accuracy of the data at the time the cost report is filed. However, if, after review of the wage data file released February 4, 2000, a hospital believed that its FY 1997 wage data were incorrectly reported, the hospital was to submit corrections along with complete, detailed supporting documentation to its intermediary by March 6, 2000. Hospitals were notified of this deadline, and of all other possible deadlines and requirements, through written communications from their fiscal intermediaries in late January 2000.

After reviewing requested changes submitted by hospitals, intermediaries transmitted any revised cost reports to HCFA and forwarded a copy of the revised Worksheet S–3, Parts II and III to the hospitals. In addition, fiscal intermediaries were to notify hospitals of the changes or the reasons that changes were not accepted. This procedure ensures that hospitals have every opportunity to verify the data that will be used to construct their wage index values. We believe that fiscal intermediaries are generally in the best position to make evaluations regarding the appropriateness of a particular cost and whether it should be included in the wage index data. However, if a

hospital disagrees with the intermediary's resolution of a requested change, the hospital may contact HCFA in an effort to resolve policy disputes. We note that the April 3, 2000 deadline also applies to these requested changes. We will not consider factual determinations at this time, as these should have been resolved earlier in the process.

Any wage data corrections to be reflected in the final wage index must have been reviewed and verified by the intermediary and transmitted to HCFA on or before April 3, 2000. (The deadline for hospitals to request changes from their fiscal intermediaries was March 6, 2000.) These deadlines are necessary to allow sufficient time to review and process the data so that the final wage index calculation can be completed for development of the final prospective payment rates to be published by August 1, 2000.

We have created the process described above to resolve all substantive wage data correction disputes before we finalize the wage data for the FY 2001 payment rates. Accordingly, hospitals that do not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage data corrections or to dispute the intermediary's decision with respect to requested changes.

The final wage data public use file will be released by May 5, 2000. Hospitals should examine both Table 3C of this proposed rule and the May 5 final public use wage data file (which reflects revisions to the data used to calculate the values in Table 3C) to verify the data HCFA is using to calculate the wage index. Hospitals will have until June 5, 2000, to submit requests to correct errors in the final wage data due to data entry or tabulation errors by the intermediary or HCFA. The correction requests that will be considered at that time will be limited to errors in the entry or tabulation of the final wage data that the hospital could not have known about before the release of the final wage data public use file.

As noted above in section III.C of this preamble, the final wage data file released on May 5, 2000 will include hospitals' teaching survey data as well as cost report data. As with the file made available in February 2000, HCFA will make the final wage data file released in May 2000 available to hospital associations and the public on the Internet. However, this file is being made available solely for the limited purpose of identifying any potential errors made by HCFA or the intermediary in the entry of the final wage data that result from the correction process described above (with the March 6 deadline). Hospitals are encouraged to review their hospital wage data promptly after the release of the final file because data presented at this time cannot be used by hospitals to initiate new wage data correction requests.

If, after reviewing the final file, a hospital believes that its wage data are incorrect due to a fiscal intermediary or HCFA error in the entry or tabulation of the final wage data, it should send a letter to both its fiscal intermediary and HCFA. The letters should outline why the hospital believes an error exists and provide all supporting information, including dates. These requests must be *received* by HCFA and the intermediaries no later than June 5, 2000. Requests mailed to HCFA should be sent to: Health Care Financing Administration; Center for Health Plans and Providers; Attention: Wage Index Team, Division of Acute Care; C4–07–07; 7500 Security Boulevard; Baltimore, MD 21244–1850. Each request must also be sent to the hospital's fiscal intermediary. The intermediary will review requests upon receipt and contact HCFA immediately to discuss its findings.

At this point in the process, changes to the hospital wage data will only be made in those very limited situations involving an error by the intermediary or HCFA that the hospital could not have known about before its review of the final wage data file. Specifically, neither the intermediary nor HCFA will accept the following types of requests at this stage of the process:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to HCFA on or before April 3, 2000.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 2000 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or HCFA during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 5, 2000) will be incorporated into the final wage index to be published by August 1, 2000 and effective October 1, 2000.

Again, we believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the intermediary's attention. Moreover, because hospitals will have access to the final wage data by early May 2000, they will have the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the development and publication of the FY 2001 wage index by August 1, 2000 and the implementation of the FY 2001 wage index on October 1, 2000. If hospitals avail themselves of this opportunity, the wage index implemented on October 1, should be virtually error free. Nevertheless, in the unlikely event that errors should occur after that date, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(w)(2), we may make midyear corrections to the wage index only in those limited circumstances in which a hospital can show (1) that the intermediary or HCFA made an error in tabulating its data; and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of FY 2001 (that is, by the June 5, 2000 deadline). As indicated earlier, since a hospital will have the opportunity to verify its data, and the intermediary will notify the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be necessary. However, should a midyear correction be necessary, the wage index change for the affected area will be effective prospectively from the date the correction is made.

IV. Other Decisions and Proposed Changes to the Prospective Payment System for Inpatient Operating Costs and Graduate Medical Education Costs

A. Expanding the Transfer Definition to Include Postacute Care Discharges (§ 412.4)

In accordance with section 1886(d)(5)(I) of the Act, the prospective payment system distinguishes between ''discharges,'' situations in which a patient leaves an acute care (prospective payment) hospital after receiving complete acute care treatment, and ''transfers,'' situations in which the patient is transferred to another acute care hospital for related care. Our policy, as set forth in the regulations at § 412.4, provides that, in a transfer situation, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Effective with discharges on or after October 1, 1998, section 1886(d)(5)(J) of the Act required the Secretary to define

and pay as transfers all cases assigned to one of 10 DRGs (identified below) selected by the Secretary if the individuals are discharged to one of the following settings:

- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term ''subsection(d) hospital'' as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.)
- A skilled nursing facility (as defined at section 1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).

Therefore, any discharge from a prospective payment hospital from one of the selected 10 DRGs that is admitted to a hospital excluded from the prospective payment system on the date of discharge from the acute care hospital, on or after October 1, 1998, would be considered a transfer and paid accordingly under the prospective payment systems (operating and capital) for inpatient hospital services. Similarly, a discharge from an acute care inpatient hospital paid under the prospective payment system to a skilled nursing facility on the same date would be defined as a transfer and paid as such. This would include cases discharged from one of the 10 selected DRGs to a designated swing bed for skilled nursing care. We consider situations in which home health services related to the condition or diagnosis of the inpatient admission are received within 3 days after the discharge as a transfer.

The statute specifies that the Secretary select 10 DRGs based upon a high volume of discharges to postacute care and a disproportionate use of postacute care services. We identified the following DRGs with the highest percentage of postacute care:

- DRG 14 (Specific Cerebrovascular Disorders Except Transient Ischemic Attack (Medical)).
- DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe (Surgical)).
- DRG 209 (Major Joint Limb Reattachment Procedures of Lower Extremity (Surgical)).
- DRG 210 (Hip and Femur Procedures Except Major Joint Procedures Age >17 with CC (Surgical)).
- DRG 211 (Hip and Femur Procedures Except Major Joint Procedures Age >17 without CC (Surgical)).
- DRG 236 (Fractures of Hip and Pelvis (Medical)).
- DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC (Surgical))
- DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC (Surgical))
- DRG 429 (Organic Disturbances and Mental Retardation (Medical))
- DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses (Surgical)).

Generally, we pay for transfers based on a per diem payment, determined by dividing the DRG payment by the average length of stay for that DRG. The transferring hospital receives twice the per diem rate the first day and the per diem rate for each following day, up to the full DRG payment. Of the 10 selected DRGs, 7 are paid under this method. However, three DRGs exhibit a disproportionate share of costs very early in the hospital stay. For these three DRGs, hospitals receive one-half of the DRG payment for the first day of the stay and one-half of the payment they would receive under the current transfer payment method, up to the full DRG payment.

Section 1886(d)(5)(J)(iv) of the Act requires the Secretary to include in the FY 2001 proposed rule a description of the effect of the provision to treat as transfers cases that are assigned to one of the 10 selected DRGs and receive postacute care upon their discharge from the hospital. Under contract with HCFA (Contract No. 500–95–0006), Health Economics Research, Inc. (HER) conducted an analysis of the impact on hospitals and hospital payments of the postacute transfer provision. The analysis sought to obtain information on four primary areas: how hospitals responded in terms of their transfer practices; a comparison of payments and costs for these cases; whether hospitals are attempting to circumvent the policy by delaying postacute care or coding the patient's discharge status as something other than a transfer; and what the next possible step is for expanding the transfer payment policy beyond the current 10 selected DRGs or the current postacute destinations.

Section 1886(d)(5)(J)(iv)(I) authorizes the Secretary to include in the proposed rule for FY 2001 a description of other post-discharge services that should be added to this postacute care transfer provision. Since FY 1999 was the first year this policy was effective and because of pending changes to payment policies for other postacute care settings such as hospital outpatient departments, we have limited data to assess whether additional postacute care settings should be included. We will continue to closely monitor this issue as more data become available.

In its analysis, HER relied on HCFA's Standard Analytic Files containing claims submission data through September 1999. However, the second and third quarter submissions for calendar year 1999 were not complete. It was decided that transfer cases would be identified by linking acute hospital discharges with postacute records based on Medicare beneficiary numbers and dates of discharge from the acute hospital with dates of admission or provision of service by the postacute provider. This method was used rather than selecting cases based on the discharge status code on the claim even though this code is being used for payment to these cases because we wanted to also assess how accurately hospitals are coding this status. However, the need to link acute and postacute episodes further limited the analytic data, due to the greater time lag for collecting postacute records. Therefore, much of HER's analysis focused on only the first two quarters of FY 1998. The two preceding fiscal years served as a baseline for purposes of comparison.

HER looked at the 10 DRGs included under the transfer payment policy and identified a slight decrease in the percentage of short-stay postacute transfers. Short-stay transfers were defined as those with a length of stay at least one day below the geometric mean length of stay for the DRG. Comparing the share of short-stay postacute transfers to total discharges shows that during the first two quarters of FY 1998, the resulting percentage was 34 percent. The same comparison during the first two quarters of FY 1999 yielded 33 percent. When HER examined the share of short-stay postacute transfers relative to all short-stay cases, it found that the percentage fell from 59 percent in FY 1998 to 58 percent in FY 1999. According to HER, ''[t]hese figures suggest that the policy change resulted in a moderate decline in the number of postacute care transfers paid for under the lower per diem methodology.''

Evidence also suggests that hospitals are keeping patients in these 10 DRGs longer prior to transfer. The mean length of stay of short-stay postacute transfers remained fairly constant prior to the change and after the change, declining less than one-half percent. On the other hand, the mean length of stay of nontransfer short-stay patients fell by

1.8 percent. By comparison, the mean length of stay of long-stay postacute transfers fell by 3.4 percent, while it fell only 2.1 percent for long-stay nontransfers. The report suggests ''[t]he relative decline in the length of stay of transfers among all long-stay cases suggests that (prospective payment system) hospitals may have responded to the policy change by holding such patients until they exceeded the geometric mean minus one day threshold prior to post-discharge referral.''

We believe these marginal reactions by hospitals to the postacute transfer policy suggest that the increase in the rate of postacute transfers over the past several years has been due to a number of factors, of which Medicare payment policy has been only one. As indicated in the Conference report accompanying Public Law 105–33 (H.R. Conf. Rept. No. 105–217, 105th Cong., 1st Sess., at 740 (1997)), Congress' intent was to ''continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.'' The preliminary results of HER's report suggest that the policy resulting from Public Law 105–33 has not had a disruptive impact on existing clinical practices.

To assess the adequacy of payments under the new policy, HER examined average profits per case prior to and after the policy change. Prior to the policy change, HER found average profits for short-stay transfers in the 10 DRGs to be $2,454 per case. Across the 10 DRGs the average profits ranged from $32,007 per case for DRG 483 to minus $26 per case for DRG 211 (the only one of the 10 DRGs with a negative profit margin prior to implementing the policy). After the policy change, the average profit per case was $1,180 per case. However, 3 of the 10 DRGs had negative average profits after implementation of the policy. The average margin for DRG 483 declined to $16,672 per case.

The study also attempted to ascertain whether there was any concerted effort to circumvent the policy by delaying transfers to avoid having a case defined as a transfer, or by not coding the case correctly on the discharge status indicator on the bill. To assess whether postacute care was being delayed, HER considered, for the periods preceding and subsequent to the policy change, the number and percent of cases admitted to either a hospital or distinct-part unit of a hospital excluded from the prospective payment system or to a skilled nursing facility 2 or 3 days following the discharge, and the number and percent of patients who received services from a home health agency 4 or 5 days after discharge from an acute care hospital. The percentages are based on the share of transferred patients falling into the time windows described above relative to all such transfers.

The analysis identified 699 patients transferred to an excluded hospital or unit 2 or 3 days following discharge from an acute care hospital during the first two quarters of FY 1998, and 660 such cases during the first two quarters of FY 1999. Similarly, there were 2,219 transfers to skilled nursing facilities 2 or 3 days after discharge during the first two quarters of FY 1998, and 1,759 during the first two quarters of FY 1999. The percentage of such transfers was constant for both excluded hospitals and units and for skilled nursing facilities. The analysis found that home health referral on the 4th or 5th day following discharge fell from 17.5 percent to 16.5 percent between the two study periods, from 12,667 cases to 9,745 cases. On the basis of these findings, HER believes ''[t]hese results do not support the contention that (prospective payment system) hospitals (would) circumvent the lower per diem payments by delaying the date of postacute care admission or visit.''

The study also examined the discharge destination codes as reported on the acute care hospital claims against postacute care transfers identified on the basis of a postacute care claim indicating the patient qualifies as a transfer. This analysis found that in 1998, only 74 percent of transfer cases had discharge destination codes on the acute care hospital claim that were consistent with whether there was a postacute care claim for the case matching the date of discharge. In FY 1999, the year the postacute care transfer policy went into effect, this rate rose to 79 percent. This indicates that hospitals are improving the accuracy of coding transfer cases.

Transfers to hospitals or units excluded from the prospective payment system must have a discharge destination code (Patient Status) of 05. Transfers to a skilled nursing facility must have a discharge destination code of 03. Transfers to a home health agency must have a discharge destination code of 06. If the hospital's continuing care plan for the patient is not related to the purpose of the inpatient hospital admission, a condition code 42 must be entered on the claim. If the continuing care plan is related to the purpose of the inpatient hospital admission, but care did not start within 3 days after the date of discharge, a condition code 43 must be entered on the claim. The presence of either of these condition codes in conjunction with discharge destination code 06 will result in full payment rather than the transfer payment amount. We intend to closely monitor the accuracy of hospitals' discharge destination coding in this regard and take whatever steps are necessary to ensure that accurate payment is made under this policy.

Section 1886(d)(5)(J)(iv)(II) of the Act authorized but did not require the Secretary to include as part of this proposed rule additional DRGs to include under the postacute care transfer provision. As part of ''The President's Plan to Modernize and Strengthen Medicare for the 21st Century'' (July 2, 1999), the Administration committed to not expanding the number of DRGs included in the policy until FY 2003. Therefore, we are not proposing any change to the postacute care settings or the 10 DRGs.

HER did undertake an analysis of how additional DRGs might be considered for inclusion under the policy. The analysis supports the initial 10 DRGs selected as being consistent with the nature of the Congressional mandate. According to HER, ''[t]he top 10 DRGs chosen initially by HCFA exhibit very large PAC [postacute care] levels and PAC discharge rates (except for DRG 264, Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC, which was paired with DRG 263). All 10 appear to be excellent choices based on the other criteria as well. Most have fairly high short-stay PAC rates (except possibly for Strokes, DRG 14, and Mental Retardation, DRG 429).''

Extending the policy beyond these initial DRGs, however, may well require more extensive analysis and grouping of like-DRGs. One concern raised in the analysis relates to single DRGs including multiple procedures with varying lengths of stay. Because the transfer payment methodology only considers the DRG overall geometric mean length of stay for a DRG, certain procedures with short lengths of stay relative to other procedures in the same DRG may be more likely to be treated as transfers. The analysis also considers pairs of DRGs, such as DRGs 263 and 264, as well as larger bundles of DRGs (grouped by common elements such as trauma, infections, and major organ procedures). According to HER, ''[i]n extending the PAC transfer policy, it is necessary to go beyond the flawed concept of a single DRG to discover multiple DRGs with a common link that

exhibit similar PAC statistics. Aggregation of this sort provides a logical bridge in expanding the PAC transfer policy that is easily justified to Congress and that avoids unintended inequities in the way DRGs—and potentially hospitals—are treated under this policy. Hospitals can be inadvertently penalized or not under the current implementation criteria due to systematic differences in the DRG mix.''

Finally, the HER report concludes with a discussion of the issues related to potentially expanding the postacute care transfer policy to all DRGs. On the positive side, HER points to the benefits of expanding the policy to include all DRGs:

- A simple, uniform formula-driven policy;
- Same policy rationale exists for all DRGs—the statutory provision requiring the Secretary to select only 10 DRGs was a political compromise;
- DRGs with little utilization of short-stay postacute care would not be harmed by the policy;
- Less confusion in discharge destination coding; and
- Hospitals that happen to be disproportionately treating the current 10 DRGs may be harmed more than hospitals with an aggressive short-stay postacute care transfer policy for other DRGs.

According to HER, the negative implications of expanding the policy to all DRGs include:

- The postacute care transfer policy is irrelevant for many DRGs;
- Added burden for the fiscal intermediaries to verify discharge destination codes;
- Diluted program savings beyond the initial 10 DRGs;
- Difficult to identify ongoing postacute care that resumes after discharge; and
- Heterogeneous procedures within single DRGs having varying lengths of stay.

At the time we developed this proposed rule, HER's report was not yet in final format. We anticipate that, by the time the final FY 2001 rule is published, this report will be available in final format. We will announce in that rule how to attain copies of the complete report.

B. Sole Community Hospitals (SCHs) (412.63, 412.73, and 413.75, Proposed New § 412.77, and § 412.92)

Under the hospital inpatient prospective payment system, special payment protections are provided to sole community hospitals (SCHs). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as, among other things, a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria a hospital must meet to be classified as an SCH are located at § 412.92(a).

Currently SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period: the Federal national rate applicable to the hospital; or the hospital's ''target amount'';—that is, either the updated hospital-specific rate based on FY 1982 costs per discharge, or the updated hospital-specific rate based on FY 1987 costs per discharge.

Section 405 of Public Law 106–113, which amended section 1886(b)(3) of the Act, provides that an SCH that was paid for its cost reporting period beginning during 1999 on the basis of either its FY 1982 or FY 1987 target amount (the hospital-specific rate as opposed to the Federal rate) may elect to receive payment under a methodology using a third hospital-specific rate based on the hospital's FY 1996 costs per discharge. This amendment to the statute means that, for discharges occurring in FY 2001, eligible SCHs can elect to use the allowable FY 1996 operating costs for inpatient hospital services as the basis for their target amount, rather than either their FY 1982 or FY 1987 costs.

We are aware that language in the Conference Report accompanying Public Law 106–113 indicates that the House bill (H.R. 3075) would have permitted SCHs that were being paid the Federal rate to rebase, not SCHs that were paid on the basis of either their FY 1982 or FY 1987 target amount (H.R. Conf. Rep. No. 106–479, 106th Cong., 1st Sess. at 890 (1999)). The language of the section 405 amendment to section 1886(b)(3) (which added new subparagraph (I)(ii)) clearly limits the option to substitute the FY 1996 base year to SCHs that were paid for their cost reporting periods beginning during 1999 on the basis of the target amount applicable to the hospital under section 1886(b)(3)(C).

When calculating an eligible SCH's FY 1996 hospital-specific rate, we propose to utilize the same basic methodology used to calculate FY 1982 and FY 1987 bases. That methodology is set forth in §§ 412.71 through 412.75 of the regulations and discussed in detail in several prospective payment system documents published in the **Federal Register** on September 1, 1983 (48 FR 3977); January 3, 1984 (49 FR 256); June 1, 1984 (49 FR 23010); and April 20, 1990 (55 FR 15150).

Since we anticipate that eligible hospitals will elect the option to rebase using their FY 1996 cost reporting periods, we are instructing our fiscal intermediaries to identify those SCHs that were paid for their cost reporting periods beginning during 1999 on the basis of their target amounts. For these hospitals, fiscal intermediaries will calculate the FY 1996 hospital-specific rate as described below in this section IV.B. If this rate exceeds a hospital's current target amount based on the greater of the FY 1982 or FY 1987 hospital-specific rate, the hospital will receive payment based on the FY 1996 hospital-specific rate (based on the blended amounts described at section 1886(b)(3)(I)(i) of the Act) unless the hospital notifies its fiscal intermediary in writing prior to the end of the cost reporting period that it does not wish to be paid on the basis of the FY 1996 hospital-specific rate. Thus, if a hospital does not notify its fiscal intermediary before the end of the cost reporting period that it declines the rebasing option, we will deem the lack of such notification as an election to have section 1886(b)(3)(I) of the Act apply to the hospital.

An SCH's decision to decline this option for a cost reporting period will remain in effect for subsequent periods until such time as the hospital notifies its fiscal intermediary otherwise.

The FY 1996 hospital-specific rate will be based on FY 1996 cost reporting periods beginning on or after October 1, 1995 and before October 1, 1996, that are 12 months or longer. If the hospital's last cost reporting period ending on or before September 30, 1996 is less than 12 months, the hospital's most recent 12-month or longer cost reporting period ending before the short period report would be utilized in the computations. If a hospital has no cost reporting period beginning in FY 1996, it would not have a hospital-specific rate based on FY 1996.

For each hospital eligible for FY 1996 rebasing, the fiscal intermediary would calculate a hospital-specific rate based on the hospital's FY 1996 cost report as follows:

- Determine the hospital's total allowable Medicare inpatient operating cost, as stated on the FY 1996 cost report.
- Divide the total Medicare operating cost by the number of Medicare discharges in the cost reporting period to determine the FY 1996 base period cost per case. For this purpose, transfers are considered to be discharges.

• In order to take into consideration the hospital's individual case-mix, divide the base year cost per case by the hospital's case-mix index applicable to the FY 1996 cost reporting period. This step is necessary to standardize the hospital's base period cost for case-mix and is consistent with our treatment of both FY 1982 and FY 1987 base-period costs per case. A hospital's case-mix is computed based on its Medicare patient discharges subject to DRG-based payment.

The fiscal intermediary will notify eligible hospitals of their FY 1996 hospital-specific rate prior to October 1, 2000. Consistent with our policies relating to FY 1982 and FY 1987 hospital-specific rates, we propose to permit hospitals to appeal a fiscal intermediary's determination of the FY 1996 hospital-specific rate under the procedures set forth in 42 CFR part 405, subpart R, which concern provider payment determinations and appeals. In the event of a modification of base period costs for FY 1996 rebasing due to a final nonappealable court judgment or certain administrative actions (as defined in § 412.72(a)(3)(i)), the adjustment would be retroactive to the time of the intermediary's initial calculation of the base period costs, consistent with the policy for rates based on FY 1982 and FY 1987 costs.

Section 405 prescribes the following formula to determine the payment for SCHs that elect rebasing:

For discharges during FY 2001:

• 75 percent of the updated FY 1982 or FY 1987 former target (identified in the statute as the ''subparagraph (C) target amount''), plus

• 25 percent of the updated FY 1996 amount (identified in the statute as the ''''rebased target amount'').

For discharges during FY 2002:

• 50 percent of the updated FY 1982 or FY 1987 former target, plus

• 50 percent of the updated FY 1996 amount.

For discharges during FY 2003:

• 25 percent of the updated FY 1982 or FY 1987 former target, plus

• 75 percent of the updated FY 1996 amount.

For discharges during FY 2004 or any subsequent fiscal year, the hospital-specific rate would be determined based on 100 percent of the updated FY 1996 amount.

We are proposing to add a new § 412.77 and amend § 412.92(d) to incorporate the provisions of section 1886(b)(3)(I) of the Act, as added by section 405 of Public Law 106–113.

Section 406 of Public Law 106–113 amended section 1886(b)(3)(B)(i)(XVI) of the Act to provide, for fiscal year 2001, for full market basket updates to both the Federal and hospital-specific payment rates applicable to sole community hospitals. We are proposing to amend § § 412.63, 412.73, and 412.75 to incorporate the amendment made by section 406 of Public Law 106–113.

C. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria a hospital must meet in order to receive special treatment under the prospective payment system as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban amount rather than the rural standardized amount. Although the other urban and rural standardized amounts were the same for discharges beginning with that date, rural referral centers would continue to receive special treatment under both the disproportionate share hospital (DSH) payment adjustment and the criteria for geographic reclassification.

As discussed in 62 FR 45999 and 63 FR 26317, under section 4202 of Public Law 105–33, a hospital that was classified as a rural referral center for FY 1991 is to be classified as a rural referral center for FY 1998 and later years so long as that hospital continued to be located in a rural area and did not voluntarily terminate its rural referral center status. Otherwise, a hospital seeking rural referral center status must satisfy applicable criteria. One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use. A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (specifying a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume). With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if its—

• Case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and

• Number of discharges is at least 5,000 per year, or if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national case-mix index value includes all urban hospitals nationwide, and the proposed regional values are the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). These values are based on discharges occurring during FY 1999 (October 1, 1998 through September 30, 1999) and include bills posted to HCFA's records through December 1999.

We are proposing that, in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2000, must have a case-mix index value for FY 1999 that is at least—

• 1.3401; or

• The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located.

The median case-mix values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2291
2. Middle Atlantic (PA, NJ, NY)	1.2387
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3116
4. East North Central (IL, IN, MI, OH, WI)	1.2602
5. East South Central (AL, KY, MS, TN)	1.2692
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1881
7. West South Central (AR, LA, OK, TX)	1.2800
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3302
9. Pacific (AK, CA, HI, OR, WA)	1.3076

The preceding numbers will be revised in the final rule to the extent required to reflect the updated FY 1999 MedPAR file, which will contain data

from additional bills received through March 31, 2000.

For the benefit of hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing each hospital's FY 1999 case-mix index value in Table 3C in section VI. of the Addendum to this proposed rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 1998 (that is, October 1, 1997 through September 30, 1998). That is the latest year for which we have complete discharge data available.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2000, must have as the number of discharges for its cost reporting period that began during FY 1999 a figure that is at least—

- 5,000; or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6,733
2. Middle Atlantic (PA, NJ, NY)	8,681
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7,845
4. East North Central (IL, IN, MI, OH, WI)	7,526
5. East South Central (AL, KY, MS, TN)	6,852
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5,346
7. West South Central (AR, LA, OK, TX)	5,380
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,026
9. Pacific (AK, CA, HI, OR, WA)	6,160

We note that the number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals. These numbers will be revised in the final rule based on the latest FY 1998 cost report data.

We reiterate that an osteopathic hospital, if it is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 2000, must have at least 3,000 discharges for its cost reporting period that began during FY 1999.

D. Indirect Medical Education (IME) Adjustment (§ 412.105)

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment to reflect the higher indirect operating costs associated with GME. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105.

Section 111 of Public Law 106–113 modified the transition for the IME adjustment that was established by Public Law 105–33. We will publish these changes in a separate interim final rule with comment period. However, for discharges occurring during FY 2001, the adjustment formula equation used to calculate the IME adjustment factor is $1.54 \times [(1 + r)^{.405} - 1]$. (The variable r represents the hospital's resident-to-bed ratio.)

In the July 30, 1999 final rule (64 FR 41517), we set forth certain policies that affected payment for both direct and indirect GME. These policies related to adjustments to full-time equivalent (FTE) resident caps for new medical residency programs affecting both direct and indirect GME programs; the adjustment to GME caps for certain hospitals under construction prior to August 5, 1997 (the enactment date of Public Law 105–33) to account for residents in new medical residency training programs; and the temporary adjustment to FTE caps to reflect residents affected by hospital closures. When we amended the regulations under § 413.86 for direct GME, we inadvertently did not make the corresponding changes in § 412.105 for IME. We are proposing to make the following conforming changes:

- To amend § 412.105(f)(1)(vii) to provide for an adjustment to the FTE caps for new medical residency programs as specified under § 413.86(g)(6).
- To add a new § 412.105(f)(1)(viii) related to the adjustment to the FTE caps for newly constructed hospitals that sponsor new residency programs in effect on or after January 1, 1995, and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, to conform to the provisions of § 413.86(g)(7).
- To add a new § 412.105(f)(1)(ix) to specify that a hospital may receive a temporary adjustment to its FTE cap to take into account residents added because of another hospital's closure if the hospital meets the criteria listed under § 413.86(g)(8).

In addition, we are proposing to add a cross-reference to ''§ 413.86(d)(3)(i) through (v)'' in § 412.105(g), and to correct the applicable period in both §§ 412.105(g) and 413.86(d)(3) by revising the phrase ''For portions of cost reporting periods beginning on or after January 1, 1998'' to read ''For portions of cost reporting periods occurring on or after January 1, 1998''.

E. Payments to Disproportionate Share Hospitals (§ 412.106)

Effective for discharges beginning on or after May 1, 1986, hospitals that treat a disproportionately large number of low-income patients (as defined in section 1886(d)(5)(F) of the Act) receive additional payments through the DSH adjustment. Section 4403(a) of Public Law 105–33 amended section 1886(d)(5)(F) of the Act to reduce the payment a hospital would otherwise receive under the current disproportionate share formula by 1 percent for FY 1998, 2 percent for FY 1999, 3 percent for FY 2000, 4 percent for FY 2001, 5 percent for 2002, and 0 percent for FY 2003 and each subsequent fiscal year. Subsequently, section 112 of Public Law 106–113 modified the amount of the reductions under Public Law 105–33 by changing the reduction to 3 percent for FY 2001 and 4 percent for FY 2002. The reduction continues to be 0 percent for FY 2003 and each subsequent fiscal year. We are proposing to revise § 412.106(e) to reflect the changes in the statute made by Public Law 106–113.

Section 112 of Public Law 106–113 also directs the Secretary to require prospective payment system hospitals to submit data on the costs incurred by the hospitals for providing inpatient and outpatient hospital services for which the hospitals are not compensated, including non-Medicare bad debt, charity care, and charges for medical and indigent care to the Secretary as part of hospitals' cost reports. These data are required for cost reporting periods beginning on or after October 1,

2001. We will be revising our instructions to hospitals for cost reports for FY 2002 to capture these data.

F. Medicare Geographic Classification Review Board (§§ 412.256 and 412.276)

With the creation of the Medicare Geographic Classification Review Board (MGCRB), beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). Implementing regulations in Subpart L of Part 412 (412.230 *et seq.*) set forth criteria and conditions for redesignations from rural to urban, rural to rural, or from an urban area to another urban area with special rules for SCHs and rural referral centers.

1. Provisions of Public Law 106–113

Section 401 of Public Law 106–113 amended section 1886(d)(8) of the Act by adding subparagraph (E), which creates a mechanism, separate and apart from the MGCRB, permitting an urban hospital to apply to the Secretary to be treated as being located in the rural area of the State in which the hospital is located. The statute directs the Secretary to treat a qualifying hospital as being located in a rural area for purposes of provisions under section 1886(d) of the Act. In addition, section 401 of Public Law 106–113 went on to incorporate the effects of such reclassifications from urban to rural for purposes of Medicare payments to outpatient departments and to hospitals that would qualify to become critical access hospitals.

Regulations implementing section 1886(d)(8)(E) of the Act are currently under development and will be published in a separate document. However, we note that the statutory language of section 1886(d)(8)(E) of the Act does not address the issue of interactions between changes in classification under section 1886(d)(8)(E) of the Act and the MGCRB reclassification process under section 1886(d)(10) of the Act. The Secretary has extremely broad authority under section 1886(d)(10) of the Act to establish criteria for reclassification under the MGCRB process. Section 401 of Public Law 106–113 does not amend section 1886(d)(10) of the Act to limit the agency's discretion under the provision in any way, nor does section 1886(d)(8)(E) of the Act (as added by section 401) refer to section 1886(d)(10) of the Act. However, we note that in the Conference Report accompanying Public Law 106–113, the language discussing the House bill (H.R. 3075, as passed) indicated that: ''[H]ospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the Medicare Geographic Reclassification Review Board for geographic reclassification to another area''.

We are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index (and thus also receive the higher payments that might result from being treated as being located in an urban area). That is, we are concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes. In light of the Conference Report language noted above discussing the House bill on the one hand, and the potential for inappropriately inconsistent treatment of the same hospital on the other hand, we are seeking public comment on this issue, and indicating our position that we may impose a limitation on such MGCRB reclassifications in the final rule for FY 2001, if such action appears warranted. We also are seeking specific comments on how such a limitation, if any, should be imposed.

For example, it could be argued that if a hospital has applied to be treated as being located in a rural area under section 1886(d)(8)(E) of the Act, then the hospital should be treated as rural for all purposes under section 1886(d), and it would be inappropriate to permit the hospital to be reclassified back to an urban area for any purpose. Under this approach, hospitals seeking reclassification under section 1886(d)(8)(E) of the Act would be treated as rural for all purposes under section 1886(d) and would be able to benefit from special provisions that apply to rural hospitals. They would not, however, be eligible for reclassification back to an urban area for either the wage index or the standardized amount. This would apply to hospitals seeking to reclassify either to their original MSA or to another MSA.

Under an alternative approach, hospitals reclassifying from urban to rural under section 1886(d)(8)(E) of the Act would be eligible to apply and be reclassified by the MGCRB like any other rural hospital (as long as applicable regulations governing MGCRB are met). This might allow hospitals to effectively pick from an array of urban and rural payment policies to maximize their Medicare payments. It could be argued that this would be the policy most consistent with the Conference Report language but we believe that it might lead to inappropriate, inconsistent classifications.

We are very concerned that the effect of unlimited MGCRB reclassifications back to the area from which a hospital was reclassified under section 1886(d)(8)(E) of the Act could have implications beyond those envisioned by Congress when it passed Public Law 106–113. However, in light of the Conference Report language, we are seeking comments on this issue. In the final rule, we might adopt one of the approaches discussed above or some other approach for addressing this issue.

Under section 152 of Public Law 106–113, certain counties are deemed to be located in specified areas for purposes of payment under the hospital inpatient prospective payment system, effective for discharges occurring on or after October 1, 2000. For payment purposes, these hospitals are to be treated as though they were reclassified for purposes of both the standardized amount and the wage index. These provisions are addressed in section III.B. of this preamble, as they relate to calculation of the FY 2001 wage indexes for hospitals in the affected counties as if they were reclassified to the specified area; and in the Addendum to this preamble as they relate to the standardized amounts.

2. Revised Thresholds Applicable to Rural Hospitals for Wage Index Reclassifications

Existing §§ 412.230(e)(1)(iii) and (e)(1)(iv) provide that hospitals may obtain reclassification to another area for purposes of calculating and applying the wage index if the hospital's average hourly wages are at least 108 percent of the average hourly wages in the area where it is physically located, and at least 84 percent of the average hourly wages in a proximate area to which the hospital seeks reclassification. These thresholds apply equally to urban and rural hospitals seeking reclassification.

Historically, the financial performance of rural hospitals under the prospective payment system has lagged behind that of urban hospitals. Despite an overall increase in recent years of Medicare inpatient operating profit margins, some rural hospitals continue to struggle financially (as measured by Medicare inpatient operating prospective payment system payments minus costs, divided by payments). For example, during FY 1997, while the national average hospital margin was 15.1 percent, it was 8.9 percent for rural hospitals. In addition, approximately one-third of rural hospitals continue to experience negative Medicare inpatient margins despite this relatively high average margin.

In response to the lower margins of rural hospitals and the potential for a negative impact on beneficiaries' access to care if these hospitals were to close, we considered potential administrative changes that could help improve payments for rural hospitals. One approach in that regard would be to make it easier for rural hospitals to reclassify for purposes of receiving a higher wage index. The current thresholds for applying for wage index reclassification are based on our previous analysis showing the average hospital wage as a percentage of its area wage was 96 percent, and one standard deviation from that average was equal to 12 percentage points (see the June 4, 1992 proposed rule (57 FR 23635) and the September 1, 1992 final rule (57 FR 39770)). Because rural hospitals' financial performance has consistently remained below that of urban hospitals, we now believe that rural hospitals merit special dispensation with respect to qualifying for reclassification for purposes of the wage index. Therefore, we are proposing to change those average wage threshold percentages so more rural hospitals can be reclassified. Specifically, we are proposing to lower the upper threshold for rural hospitals to 106 percent and the lower threshold to 82 percent. The thresholds for urban hospitals seeking reclassification for purposes of the wage index would be unchanged. We would note that rural hospitals comprised nearly 90 percent of FY 2000 wage index reclassifications. Under this proposal, beginning October 1, 2000, rural hospitals would be able to reclassify for the wage index if, among other things, their average hourly wages are at least 106 percent of the area in which they are physically located, and at least 82 percent of the average hourly wages in the proximate area to which it seeks reclassification.

Although it is difficult to estimate precisely how many additional hospitals might qualify by lowering the thresholds because we do not have data indicating which hospitals meet all of the other reclassification criteria (*e.g.,* proximity), our analysis indicates that, if we were to raise the 108 percent threshold to 109 percent, approximately 20 rural hospitals would no longer qualify. If the upper threshold were to be raised to 110 percent, another 16 hospitals would not qualify. On the other hand, increasing the lower threshold from 84 percent to 85 percent would result in only 2 rural hospitals becoming ineligible to reclassify. Only 1 additional hospital would be affected by raising the threshold to 86 percent. Based on this analysis, we anticipate approximately 50 rural hospitals are likely to benefit from this proposed change.

We believe this proposal achieves an appropriate balance between allowing certain hospitals that are currently just below the thresholds to become eligible for reclassification, while not liberalizing the criteria so much that an excessive number of hospitals begin to reclassify. Because these reclassifications are budget neutral, nonreclassified hospitals' payments are negatively impacted by reclassification.

We believe there are many factors associated with lower margins among rural hospitals. We would note that section 410 of Public Law 106–113 requires the Comptroller General of the United States to ''conduct a study of the current laws and regulations for geographic reclassification of hospitals to determine whether such reclassification is appropriate for purposes of applying wage indices.'' In addition, section 411 of Public Law 106–113 requires MedPAC to conduct a study on the adequacy and appropriateness of the special payment categories and methodologies established for rural hospitals. We anticipate that the results of these studies will help identify other areas to help improve payments for rural hospitals, either through reclassifications or other means.

G. Payment for Direct Costs of Graduate Medical Education (§ 413.86)

1. Background

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education (GME). The payments are based on the number of residents trained by the hospital. Section 1886(h) of the Act, as amended by section 4623 of Public Law 105–33, caps the number of residents that hospitals may count for direct GME.

Section 9202 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (Public Law 99–272) established a methodology for determining payments to hospitals for the costs of approved GME programs at section 1886(h)(2) of the Act. Section 1886(h)(2) of the Act, as implemented in regulations at § 413.86(e), sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983 through September 30, 1984). The PRA is multiplied by the number of full-time equivalent (FTE) residents working in all areas of the hospital complex (or non-hospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments. In addition, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital's PRA for the previous cost reporting period is not adjusted for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals with both primary care/obstetrics and gynecology residents and non-primary care residents have two separate PRAs for FY 1994 and, thereafter, one for primary care and one for non-primary care. (Thus, for purposes of this proposed rule, when we refer to a hospital's PRA, this amount is inclusive of any CPI–U adjustments the hospital may have received since the hospital's base-year, including any CPI-U adjustments the hospital may have received because the hospital trains primary care/non-primary care residents, as specified under existing § 413.86(e)(3)(ii)).

2. Use of National Average Per Resident Amount Methodology in Computing Direct GME Payments

Section 311 of Public Law 106–113 amended section 1886(h)(2) of the Act to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005. Generally, section 311 establishes a ''floor'' and a ''ceiling'' based on a locality-adjusted, updated, weighted average PRA. Each hospital's PRA is compared to the floor and ceiling to determine whether its PRA should be

revised. Accordingly, we are proposing to implement section 311 by setting forth the prescribed methodology for calculation of the weighted average PRA. We then discuss the proposed steps for determining whether a hospital's PRA will be adjusted based upon the proposed calculated weighted average PRA, in accordance with the methodology specified under section 311 of Public Law 106–113.

We propose to calculate the weighted average PRA based upon data from hospitals' cost reporting periods ending during FY 1997 (October 1, 1996 through September 30, 1997), as directed by section 311 of Public Law 106–113. We accessed these FY 1997 cost reporting data from the Hospital Cost Report Information System (HCRIS) and also obtained the necessary data for those hospitals that are not included in HCRIS (because they file manual cost reports), from those hospitals' fiscal intermediaries. If a hospital had more than one cost reporting period ending in FY 1997, we propose to include all of its cost reports ending in FY 1997 in our calculations. However, if a hospital did not have a cost reporting period ending in FY 1997, such as a hospital with a long cost reporting period beginning in FY 1996 and ending in FY 1998, the hospital is excluded from our calculations. One hospital is excluded from our calculation even though it did have a cost reporting period ending during FY 1997 because, at that time, it was a new teaching hospital with no established PRA (the first year of training for a new teaching hospital is paid for by Medicare on a cost basis; a PRA is applied in calculating a hospital's payment beginning with the hospital's second year of residency training). The total number of hospitals that we include in our calculation is 1,235. Thirty-five of these hospitals are hospitals with more than one cost report.

In accordance with section 311 of Public Law 106–113, we propose to calculate the weighted average PRA in the following manner:

Step 1: We determine each hospital's single PRA by adding each hospital's primary care and non-primary care PRAs, weighted by its respective FTEs, and dividing by the sum of the FTEs for primary care and non-primary care residents.

Step 2: We standardize each hospital's single PRA by dividing it by the 1999 geographic adjustment factor (GAF) (which is an average of the three geographic index values (weighted by the national average weight for the work component, practice expense component, and malpractice component)) in accordance with section 1848(e) of the Act and 42 CFR 414.26 (which is used to adjust physician payments for the different wage areas), for the physician fee schedule area in which the hospital is located.

Step 3: We add all the standardized hospital PRAs (as calculated in Step 2), each weighted by hospitals' respective FTEs, and then divide by the total number of FTEs.

Based upon this three-step calculation, we have determined the proposed weighted average PRA (for cost reporting periods ending during FY 1997) to be $68,487.

For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005 (FY 2001 through FY 2005), the national average PRA is applied using the following three steps:

Step 1: Update the weighted average PRA for inflation. Under section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, the weighted average PRA is updated by the estimated percentage increase in the consumer price index for all urban consumers (CPI–U) during the period beginning with the month that represents the midpoint of the cost reporting *periods* ending during FY 1997 and ending with the midpoint of the hospital's cost reporting *period* that begins in FY 2001. Therefore, the weighted average standardized PRA ($68,487) would be updated by the increase in CPI–U for the period beginning with the midpoint of *all cost* reporting periods for hospitals with cost reporting periods ending during FY 1997 (October 1, 1996), and ending with the midpoint of the *individual* hospital's cost reporting period that begins during FY 2001.

For example, Hospital A has a calendar year cost reporting period. Thus, for Hospital A, the weighted average PRA is updated from October 1, 1996 to July 1, 2001, because July 1 is the midpoint of its cost reporting period beginning on or after October 1, 2000. Or, for example, if Hospital B has a cost reporting period starting October 1, the weighted average PRA is updated from October 1, 1996 to April 1, 2001, the midpoint of the cost reporting period for Hospital B. Therefore, the starting point for updating the weighted average PRA is the same date for all hospitals (October 1, 1996), but the ending date is different because it is dependent upon the cost reporting period for each hospital.

Step 2: Adjust for locality. In accordance with section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, once the weighted average PRA is updated according to each hospital's cost reporting period, the updated weighted average PRA (the national average PRA) would be further adjusted to calculate a locality-adjusted national average PRA for each hospital. This is done by multiplying the updated national average PRA by the 1999 GAF (as specified in the October 31, 1997 **Federal Register** (62 FR 59257)) for the fee schedule area in which the hospital is located.

Step 3: Determine possible revisions to the PRA. For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, the locality-adjusted national average PRA, as calculated in Step 2, is then compared to the hospital's individual PRA. Based upon the provisions of section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, a hospital's PRA would be revised, if appropriate, according to the following:

- Floor—For cost reporting periods beginning in FY 2001, to determine which PRAs (primary care and non-primary care separately) are below the 70 percent floor, a hospital's locality-adjusted national average PRA is multiplied by 70 percent. This resulting number is then compared to the hospital's PRA that is updated for inflation to the current cost reporting period. If the hospital's PRA would be less than 70 percent of the locality-adjusted national average PRA, the individual PRA is replaced by 70 percent of the locality-adjusted national average PRA for that cost reporting period and would be updated for inflation in future years by the CPI–U.

We note that there may be some hospitals with primary care and non-primary care PRAs where both PRAs are replaced by 70 percent of the locality-adjusted national average PRA. In these situations, the hospital would receive identical PRAs; no distinction in PRAs would be made for differences in inflation (because a hospital has both primary care and non-primary care PRAs, each of which is updated as described in § 413.86(e)(3)(ii)) as of cost reporting periods beginning on or after October 1, 2000.

For example, if the FY 2001 locality-adjusted national average PRA for Area X is $100,000, then 70 percent of that amount is $70,000. If, in Area X, Hospital A has a primary care FY 2001 PRA of $69,000 and a non-primary care FY 2001 PRA of $67,000, both of Hospital A's FY 2001 PRAs are replaced by the $70,000 floor. Thus, $70,000 is the amount that would be used to determine Hospital A's direct GME payments for both primary care and

non-primary care FTEs in its cost reporting period beginning in FY 2001, and the $70,000 PRA would be updated for inflation by the CPI–U in subsequent years.

• *Ceiling*—For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005 (FY 2001 through FY 2005), a ceiling that is equal to 140 percent of each locality-adjusted national average PRA would be calculated and compared to each individual hospital's PRA. If the hospital's PRA is greater than 140 percent of the locality-adjusted national average PRA, the PRA would be adjusted depending on the fiscal year as follows:

a. FY 2001

For cost reporting periods beginning in FY 2001, each hospital's PRA from the preceding cost reporting period (that is, FY 2000) is compared to the FY 2001 locality-adjusted national average PRA. If the individual hospital's FY 2000 PRA exceeds 140 percent of the FY 2001 locality-adjusted national average PRA, the PRA is frozen at the FY 2000 PRA, and is not updated in FY 2001 by the CPI–U factor, subject to the limitation in section IV.G.2.d. of this preamble.

For example, if the FY 2001 locality-adjusted national average PRA ''ceiling'' for Area Y is $140,000 (that is, 140 percent of $100,000, the hypothetical locality-adjusted national average PRA), and if, in this area, Hospital B has a FY 2000 PRA of $140,001, then for FY 2001, Hospital B's PRA is frozen at $140,001 and is not updated by the CPI–U for FY 2001.

b. FY 2002

For cost reporting periods beginning in FY 2002, the methodology used to calculate each hospital's individual PRA would be the same as described in section IV.G.2.a. above for FY 2001. Each hospital's PRA from the preceding cost reporting period (that is, FY 2001) is compared to the FY 2002 locality-adjusted national average PRA. If the individual hospital's FY 2001 PRA exceeds 140 percent of the FY 2002 locality-adjusted national average PRA, the PRA is frozen at the FY 2001 PRA, and is not updated in FY 2002 by the CPI–U factor, subject to the limitation in section IV.G.2.d. of this preamble.

c. FY 2003, FY 2004, and FY 2005

For cost reporting periods beginning in FY 2003, FY 2004, and FY 2005, if the hospital's PRA for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average PRA for that same previous cost reporting period (for example, for the cost reporting period beginning in FY 2003, compare the hospital's PRA from the FY 2002 cost reporting period to the locality-adjusted national average PRA from FY 2002), then, subject to the limitation in section IV.G.2.d. of this preamble, the hospital's PRA is updated in accordance with section 1886(h)(2)(D)(i) of the Act, except that the CPI–U applied is reduced (but not below zero) by 2 percentage points.

For example, for purposes of Hospital A's FY 2003 cost report, Hospital A's PRA for FY 2002 is compared to Hospital A's locality-adjusted national average PRA ceiling for FY 2002. If, in FY 2002, Hospital A's PRA is $100,001 and the FY 2002 locality-adjusted national average PRA ceiling is $100,000, then for FY 2003, Hospital A's PRA is updated with the FY 2003 CPI–U minus 2 percent. If, in this scenario, the CPI–U for FY 2003 is 1.024, Hospital A would update its PRA in FY 2003 by 1.004 (the CPI–U minus 2 percentage points). However, if the CPI–U factor for FY 2003 is 1.01 and subtracting 2 percentage points of 1.01 yields 0.99, the PRA for FY 2003 would not be updated, and would remain $100,001.

We note that, while the language in section 1886(h)(2)(D)(iv)(I) and in section 1886(h)(2)(D)(iv)(II) of the Act (the sections that describe the adjustments to PRAs for hospitals that exceed 140 percent of the locality-adjusted national average PRA) is very similar, the language does differ. Section 1886(h)(2)(D)(iv)(I) of the Act states that for a cost reporting period beginning during FY 2000 or FY 2001, ''if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality-adjusted national average per resident amount * * * *for that hospital and period* * * *, the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for such preceding cost reporting period.'' (Emphasis added.) Section 1886(h)(2)(D)(iv)(II) of the Act states that for a cost reporting period beginning during FY 2003, FY 2004, or FY 2005, ''if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality-adjusted national average per resident amount * * * *for that hospital and preceding period*, the approved FTE resident amount for the period involved shall be updated * * . *.'' (Emphasis added.) Accordingly, for FYs 2001 and 2002, a hospital's PRA from the previous cost reporting period is compared to the locality-adjusted national average PRA of the current cost reporting period. For FY 2003, FY 2004, or FY 2005, a hospital's PRA from the previous cost reporting period is compared to the locality-adjusted national average PRA from the previous cost reporting period.

d. General Rule for Hospitals That Exceed the Ceiling

For cost reporting periods beginning in FY 2001 through FY 2005, if a hospital's PRA exceeds 140 percent of the locality-adjusted national average PRA and it is adjusted under any of the above criteria, the current year PRA cannot be reduced below 140 percent of the locality-adjusted national average PRA.

For example, to determine the PRA of Hospital A, in FY 2003, Hospital A had a FY 2002 PRA of $100,001 and the FY 2002 locality-adjusted national average PRA ceiling is $100,000. For FY 2003, applying an update of the CPI–U factor minus 2 percentage points (for example, 1.024 − .02 = 1.004 would yield an updated PRA of $100,401) while the locality-adjusted national average PRA (before calculation of the ceiling) is updated for FY 2003 with the full CPI–U factor (1.024) so that the ceiling of $100,000 is now increased to $102,400 (that is, $100,000 × 1.024 = $102,400). Therefore, applying the adjustment would result in a PRA of $100,401, which is under the ceiling of $102,400 for FY 2003. In this situation, for purposes of the FY 2003 cost report, Hospital A's PRA equals $102,400.

We note that if the hospital's PRA *does not* exceed 140 percent of the locality-adjusted national average PRA, the PRA is updated by the CPI–U for the respective fiscal year. If a hospital's PRA is updated by the CPI–U because it is less than 140 percent of the locality-adjusted national average PRA for a respective fiscal year, and once updated, the PRA exceeds the 140 percent ceiling for the respective fiscal year, the updated PRA would still be used to calculate the hospital's direct GME payments. Whether a hospital's PRA exceeds the ceiling is determined *before* the application of the update factors; if a hospital's PRA exceeds the ceiling only because of the application of the update factors, the hospital's PRA would retain the CPI–U factors.

For example, if, in FY 2001, the locality-adjusted national average PRA ceiling for Area Y is $140,000, and if, in this area, Hospital B has a FY 2000 PRA of $139,000, then for FY 2001, Hospital B's PRA is updated for inflation for FY 2001 because the PRA is below the ceiling. However, once the update factors are applied, Hospital B's PRA is now $142,000 (that is, above the $140,000 ceiling). In this scenario,

Hospital B's inflated PRA would be used to calculate its direct GME payments because Hospital B has only exceeded the ceiling *after* the application of the inflation factors.

• *PRAs greater than or equal to the floor and less than or equal to the ceiling.* For cost reporting periods beginning in FY 2001 through FY 2005, if a hospital's PRA is greater than or equal to 70 percent and less than or equal to 140 percent of the locality-adjusted national average PRA, the hospital's PRA is updated using the existing methodology specified in § 413.86(e)(3)(i).

For cost reporting periods beginning in FY 2006 and thereafter, a hospital's PRA for its preceding cost reporting period would be updated using the existing methodology specified in § 413.86(e)(3)(i).

We are proposing to redesignate the existing § 413.86(e)(4) as § 413.86(e)(5) and add the rules implementing section 1886(h)(2) of the Act, as amended by section 311 of Public Law 106–113, in the vacated § 413.86(e)(4). Because we are proposing to apply the methodology for updating the PRA for inflation that is described in existing § 413.86(e)(3), we also are proposing to amend § 413.86(e)(3) to make those rules applicable to the cost reporting periods (FY 2001 through FY 2005) specified in the proposed § 413.86(e)(4), and in subsequent cost reporting periods.

In addition, we are proposing to make a conforming change by amending proposed redesignated § 413.86(e)(5) to account for situations in which hospitals do not have a 1984 base period and establish a PRA in a cost reporting period beginning on or after October 1, 2000. We believe there are two factors to consider when a new teaching hospital establishes its PRA under proposed redesignated § 413.86(e)(5). First, for example, when calculating the weighted mean value of PRAs of hospitals located in the same geographic area or the weighted mean of the PRAs in the hospital's census region (as specified in § 412.62(f)(1)(i)), the hospitals' PRAs used to calculate the weighted mean values are subject to the provisions of proposed § 413.86(e)(4), the national average PRA methodology. Second, the resulting PRA established under proposed redesignated § 413.86(e)(5) also would be subject to the national average PRA methodology specified in proposed § 413.86(e)(4).

We also are making a clarifying amendment to the proposed redesignated § 413.86(e)(5)(i)(B) to account for an oversight in the regulations text when we amended our regulations on August 29, 1997 (62 FR 46004). In the preamble of the August 29, 1997 final rule, in setting forth our policy on the determination of per resident amounts for hospitals that did not have residents in the 1984 GME base period, we stated that we would use a ''weighted'' average of the per resident amounts for hospitals located in the same geographic area. However, we inadvertently did not include a specific reference to ''weighted'' in the language of the regulation text. Therefore, we are proposing to specify that the ''weighted mean value'' of per resident amounts of hospitals located in the same geographic wage area is used for determining the base period for certain hospitals for cost reporting periods beginning in the same fiscal years.

H. Outliers: Miscellaneous Change

Under the provisions of section 1886(d)(5)(A)(i) of the Act, the Secretary does not pay for day outliers for discharges from hospitals paid under the prospective payment systems that occur after September 30, 1997. We are proposing to make a conforming change to § 412.2(a) by deleting the reference to an additional payment for both inpatient operating and inpatient capital-related costs for cases that have an atypically long length of stay.

V. The Prospective Payment System for Capital-Related Costs: The Last Year of the Transition Period

Since FY 2001 is the last year of the 10-year transition period established to phase in the prospective payment system for hospital capital-related costs, for the readers' benefit, we are providing a summary of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals, and the policy for providing exceptions payments during the transition period.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the capital prospective payment system. We initially implemented the capital prospective payment system in the August 30, 1991 final rule (56 FR 43409), in which we established a 10-year transition period to change the payment methodology for Medicare inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The 10-year transition period established to phase in the prospective payment system for capital-related costs is effective for discharges occurring on or after October 1, 1991 (FY 1992) through discharges occurring on or before September 30, 2001. For FY 2001, hospitals paid under the fully prospective transition period methodology will be paid 100 percent of the Federal rate and zero percent of their hospital-specific rate, while hospitals paid under the hold-harmless transition period methodology will be paid 85 percent of their allowable old capital costs (100 percent for sole community hospitals) plus a payment for new capital costs based on the Federal rate. Fiscal year 2001 is the final year of the capital transition period and, therefore, the last fiscal year for which a portion of a hold-harmless hospital's capital costs per discharge will be paid on a cost basis (except for new hospitals). Also, since fully prospective hospitals will be paid based on 100 percent of the Federal rate and zero percent of their hospital-specific rate, we will not determine a hospital-specific rate update for FY 2001 in section IV of the Addendum of this proposed rule. Beginning with discharges occurring on or after October 1, 2001 (FY 2002), payment for capital-related costs will be determined based solely on the capital standard Federal rate. Hospitals that were defined as ''Anew'' for the purposes of capital payments during the transition period (§ 412.30(b)) will continue to be paid according to the applicable payment methodology outlined in § 412.324.

Generally, during the transition period, inpatient capital-related costs are paid on a per discharge basis, and the amount of payment depends on the relationship between the hospital-specific rate and the Federal rate during the hospital's base year. A hospital with a base year hospital-specific rate lower than the Federal rate is paid under the fully prospective payment methodology during the transition period. This method is based on a dynamic blend percentage of the hospital's hospital-specific rate and the applicable Federal rate for each year during the transition period. A hospital with a base period hospital-specific rate greater than the Federal rate is paid under the hold-harmless payment methodology during the transition period. A hospital paid under the hold-harmless payment methodology receives the higher of (1) a blended payment of 85 percent of reasonable cost for old capital plus an amount for new capital based on a portion of the Federal rate or (2) a

payment based on 100 percent of the adjusted Federal rate. The amount recognized as old capital is generally limited to the allowable Medicare capital-related costs that were in use for patient care as of December 31, 1990. Under limited circumstances, capital-related costs for assets obligated as of December 31, 1990, but put in use for patient care after December 31, 1990, also may be recognized as old capital if certain conditions are met. These costs are known as obligated capital costs. New capital costs are generally defined as allowable Medicare capital-related costs for assets put in use for patient care after December 31, 1990. Beginning in FY 2001, at the conclusion of the transition period for the capital prospective payment system, capital payments will be based solely on the Federal rate for the vast majority of hospitals.

During the transition period, new hospitals are exempt from the prospective payment system for capital-related costs for their first 2 years of operation and are paid 85 percent of their reasonable cost during that period. The hospital's first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) beginning at least 1 year after the hospital accepts its first patient serves as the hospital's base period. Those base year costs qualify as old capital and are used to establish its hospital-specific rate used to determine its payment methodology under the capital prospective payment system. Effective with the third year of operation, the hospital is paid under either the fully prospective methodology or the hold-harmless methodology. If the fully prospective methodology is applicable, the hospital is paid using the appropriate transition blend of its hospital-specific rate and the Federal rate for that fiscal year until the conclusion of the transition period, at which time the hospital will be paid based on 100 percent of the Federal rate. If the hold-harmless methodology is applicable, the hospital will receive hold-harmless payment for assets in use during the base period for 8 years, which may extend beyond the transition period.

The basic methodology for determining capital prospective payments based on the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG Weight) × (GAF) × (Large Urban Add-on, if applicable) x (COLA Adjustment for Hospitals Located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor).

Hospitals may also receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments.

During the capital prospective payment system transition period, a hospital may also receive an additional payment under an exceptions process if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs for qualifying classes of hospitals. For up to 10 years after the conclusion of the transition period, a hospital may also receive an additional payment under a special exceptions process if certain qualifying criteria are met and its total inpatient capital-related payments are less than the 70 percent minimum percentage of its allowable Medicare inpatient capital-related costs.

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, under amendments to the Act enacted by section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs.

In the August 30, 1991 final rule, we established a capital exceptions policy, which provides for exceptions payments during the transition period (§ 412.348). Section 412.348 provides that, during the transition period, a hospital may receive additional payment under an exceptions process when its regular payments are less than a minimum percentage, established by class of hospital, of the hospital's reasonable capital-related costs. The amount of the exceptions payment is the difference between the hospital's minimum payment level and the payments the hospital would receive under the capital prospective payment system in the absence of an exceptions payment. The comparison is made on a cumulative basis for all cost reporting periods during which the hospital is subject to the capital prospective payment transition rules. The minimum payment percentages for regular capital exceptions payments by class of hospitals for FY 2001 are:

- For sole community hospitals, 90 percent;
- For urban hospitals with at least 100 beds that have a disproportionate share patient percentage of at least 20.2 percent or that received more than 30 percent of their net inpatient care revenues from State or local governments for indigent care, 80 percent;
- For all other hospitals, 70 percent of the hospital's reasonable inpatient capital-related costs.

The provision for regular exceptions payments will expire at the end of the transition period. Payments will no longer be adjusted to reflect regular exceptions payments at § 412.348. Accordingly, for cost reporting periods beginning on or after October 1, 2001, hospitals will receive only the per discharge payment based on the Federal rate for capital costs (plus any applicable DSH or IME and outlier adjustments) unless a hospital qualifies for a special exceptions payment under § 412.348(g).

Under the special exceptions provision at § 412.348(g), an additional payment may be made for up to 10 years beyond the end of the capital prospective payment system transition period for eligible hospitals. The capital special exceptions process is budget neutral; that is, even after the end of the capital prospective payment system transition, we will continue to make an adjustment to the capital Federal rate in a budget neutral manner to pay for exceptions, as long as an exceptions policy is in force. Currently, the limited

special exceptions policy will allow for exceptions payments for 10 years beyond the conclusion of the 10-year capital transition period or through September 30, 2011.

VI. Proposed Changes for Hospitals and Hospital Units Excluded From the Prospective Payment System

A. Limits on and Adjustments to the Target Amounts for Excluded Hospitals and Units (§ 413.40(b)(4) and (g))

1. Updated Caps

Section 1886(b)(3) of the Act (as amended by section 4414 of Public Law 105–33) establishes caps on the target amounts for certain existing excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. The caps on the target amounts apply to the following three classes of excluded hospitals: Psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

A discussion of how the caps on the target amounts were calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46018); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000), and the July 30, 1999 final rule (64 FR 41529). For purposes of calculating the caps on existing facilities, the statute required us to calculate the national 75th percentile of the target amounts for each class of hospital (psychiatric, rehabilitation, or long-term care) for cost reporting periods ending during FY 1996. Under section 1886(b)(3)(H)(iii) of the Act, the resulting amounts are updated by the market basket percentage to the applicable fiscal year. However, section 121 of Public Law 106–113 amended section 1886(b)(3)(H) of the Act to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals, effective for cost reporting periods beginning on or after October 1, 1999, through September 30, 2002. We intend to publish an interim final rule with comment period implementing this provision for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000. This proposed rule addresses the wage adjustment to the caps for cost reporting periods beginning on or after October 1, 2000.

For purposes of calculating the caps, section 1886(b)(3)(H)(ii) of the Act requires the Secretary to first ''estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996.'' Furthermore, section 1886(b)(3)(H)(iii), as added by Public Law 106–113, requires the Secretary to provide for ''an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account the differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''

Consistent with the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act to determine the appropriate wage adjustment, we propose to account for differences in wage-related costs by adjusting the caps to account for the following:

First, we would adjust each hospital's target amount to account for area differences in wage-related costs. For each class of hospitals (psychiatric, rehabilitation, and long-term care), we would determine the labor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the labor-related portion of costs (or 0.71553). Similarly, we would determine the nonlabor-related portion of each hospital's FY 1996 target amount by multiplying its target amount by the actuarial estimate of the nonlabor-related portion of costs (or 0.28447).

Next, we would account for wage differences among hospitals within each class by dividing the labor-related portion of each hospital's target amount by the hospital's FY 1998 hospital wage index under the hospital inpatient prospective payment system (see § 412.63), as shown in Tables 4A and 4B of the August 29, 1997 final rule (62 FR 46070). Within each class, each hospital's wage-adjusted target amount would be calculated by adding the wage-adjusted labor-related portion of its target amount and the nonlabor-related portion of its target amount. Then, the wage-adjusted target amounts for hospitals within each class would be arrayed in order to determine the national 75th percentile caps on the target amounts for each class.

This adjustment methodology for the national 75th percentile of the target amounts is identical to the methodology we utilized for the wage index adjustment described in the August 29, 1997 final rule (62 FR 46020) to calculate the wage-adjusted 110 percent of the national median target amounts for new excluded hospitals and units. Again, we recognize that wages may differ for prospective payment hospitals and excluded hospitals, but we believe that the wage data reflect area differences in wage-related costs. Moreover, in light of the short timeframe for implementing this provision, we would use the wage data for acute hospitals since they are the most feasible data source.

In the July 30, 1999 final rule (64 FR 41529), we established the FY 2000 caps on the target amounts as follows:

- Psychiatric hospitals and units: $11,110.
- Rehabilitation hospitals and units: $20,129.
- Long-term care hospitals: $39,712.

Therefore, based on these previously calculated caps on the target amounts and consistent with the broad authority conferred on the Secretary by section 1886(b)(3)(H)(iii) of the Act to determine the appropriate wage adjustment to the caps, we have determined the labor-related and nonlabor-related portions of the proposed caps on the target amounts for FY 2001 using the methodology outlined above.

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$8,106	$3,223
Rehabilitation	15,108	6,007
Long-Term Care	29,312	11,654

These labor-related and nonlabor-related portions of the proposed caps on the target amounts for FY 2001 are based on the current estimate of the market basket increase for excluded hospitals and units for FY 2001 of 3.1 percent.

In the interim final rule with comment period that we plan to publish, we will revise §§ 413.40(c)(4)(i) and (c)(4)(ii) to incorporate the changes in the formula used to determine the limitation on the target amounts for excluded hospitals and units, as provided for by section 121 of Public Law 106–113.

Finally, to determine payments described in § 413.40(c), the cap on the hospital's target amount per discharge is determined by adding the hospital's nonlabor-related portion of the national 75th percentile cap to its wage-adjusted, labor-related portion of the national 75th percentile cap. A hospital's wage-adjusted, labor-related portion of the target amount is calculated by multiplying the labor-related portion of the national 75th percentile cap for the hospital's class by the hospital's applicable wage index. For FY 2001, a hospital's applicable wage index is the wage index under the hospital inpatient prospective payment system (see § 412.63), for cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30,

2001 as shown in Tables 4A and 4B of this proposed rule. A hospital's applicable wage index corresponds to the area in which the hospital or unit is physically located (MSA or rural area) and is not subject to prospective payment system hospital reclassification under section 1886(d)(10) of the Act.

2. Updated Caps for New Excluded Hospitals and Units (§ 413.40(f))

Section 1886(b)(7) of the Act establishes a payment methodology for new psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. Under the statutory methodology, for a hospital that is within a class of hospitals specified in the statute and that first receives payments as a hospital or unit excluded from the prospective payment system on or after October 1, 1997, the amount of payment will be determined as follows: For the first two 12-month cost reporting periods, the amount of payment is the lesser of (1) the operating costs per case; or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period in which the hospital receives payments and adjusted for differences in area wage levels.

The proposed amounts included in the following table reflect the updated 110 percent of the wage neutral national median target amounts for each class of excluded hospitals and units for cost reporting periods beginning during FY 2001. These figures are updated to reflect the projected market basket increase of 3.1 percent. For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$6,592	$2,623
Rehabilitation	12,964	5,154
Long-Term Care	16,708	6,643

3. Development of Prospective Payment System for Inpatient Rehabilitation Hospitals and Units

Section 4421 of Public Law 105–33 added section 1886(j) to the Act. Section 1886(j) of the Act mandates the phase-in of a case-mix adjusted prospective payment system for inpatient rehabilitation services (freestanding hospitals and units) for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2002. The prospective payment system will be fully implemented for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) was amended by section 125 of Public Law 106–113 to require the Secretary to use the discharge as the payment unit under the prospective payment system for inpatient rehabilitation services and to establish classes of patient discharges by functional-related groups.

We will issue a separate notice of proposed rulemaking in the **Federal Register** on the prospective payment system for inpatient rehabilitation facilities. That document will discuss the requirements in section 1886(j)(1)(A)(i) of the Act for a transition phase covering the first two cost reporting periods under the prospective payment system. During this transition phase, inpatient rehabilitation facilities will receive a payment rate comprised of a blend of the facility specific rate (the TEFRA percentage) based on the amount that would have been paid under Part A with respect to these costs if the prospective payment system would not be implemented and the inpatient rehabilitation facility prospective payment rate (prospective payment percentage). As set forth in sections 1886(j)(1)(C)(i) and (ii) of the Act, the TEFRA percentage for a cost reporting period beginning on or after October 1, 2000, and before October 1, 2001, is 66⅔ percent; the prospective payment percentage is 33⅓ percent. For cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002, the TEFRA percentage is 33⅓ percent and the prospective payment percentage is 66⅔ percent.

As provided in section 1886(j)(3)(A) of the Act, the prospective payment rates will be based on the average inpatient operating and capital costs of rehabilitation facilities and units. Payments will be adjusted for case-mix using patient classification groups, area wages, inflation, outlier status and any other factors the Secretary determines necessary. We will propose to set prospective payment amounts in effect during FY 2001 so that total payments under the system are projected to equal 98 percent of the amount of payments that would have been made under the current payment system. Outlier payments in a fiscal year may not be projected or estimated to exceed 5 percent of the total payments based on the rates for that fiscal year.

4. Continuous Improvement Bonus Payment

Under § 413.40(d)(4), for cost reporting periods beginning on or after October 1, 1997, an ''eligible'' hospital may receive continuous improvement bonus payments in addition to its payment for inpatient operating costs plus a percentage of the hospital's rate-of-increase ceiling (as specified in § 413.40(d)(2)). An eligible hospital is a hospital that has been a provider excluded from the prospective payment system for at least three full cost reporting periods prior to the applicable period and the hospital's operating costs per discharge for the applicable period are below the lowest of its target amount, trended costs, or expected costs for the applicable period. Prior to enactment of Public Law 106–113, the amount of the continuous improvement bonus payment was equal to the lesser of—

(a) 50 percent of the amount by which operating costs were less than the expected costs for the period; or

(b) 1 percent of the ceiling.

Section 122 of Public Law 106–113 amended section 1886(b)(2) of the Act to provide, for cost reporting periods beginning on or after October 1, 2000, and before September 30, 2001, for an increase in the continuous improvement bonus payment for long-term care and psychiatric hospitals and units. Under section 1886(b)(2) of the Act, as amended, a hospital that is within one of these two classes of hospitals (psychiatric hospitals or units and long-term-care hospitals) will receive the lesser of 50 percent of the amount by which the operating costs are less than the expected costs for the period, or the increased percentages mandated by statute as follows:

(a) For a cost reporting period beginning on or after October 1, 2000 and before September 30, 2001, 1.5 percent of the ceiling; and

(b) For a cost reporting period beginning on or after October 1, 2001, and before September 30, 2002, 2 percent of the ceiling.

We are proposing to revise § 413.40(d)(4) to incorporate this provision of the statute.

B. Responsibility for Care of Patients in Hospitals-Within-Hospitals (§ 413.40(a)(3))

Effective October 1, 1999, for hospitals-within-hospitals, we implemented a policy that allows for a 5-percent threshold for cases in which a patient discharged from an excluded hospital-within-a-hospital and admitted to the host hospital was subsequently

readmitted to the excluded hospital-within-a-hospital. With respect to these cases, if the excluded hospital exceeds the 5-percent threshold, we do not include any previous discharges to the prospective payment hospital in calculating the excluded hospital's cost per discharge. That is, the entire stay is considered one Medicare ''discharge'' for purposes of payments to the excluded hospital. The effect of this rule, as explained more fully in the May 7, 1999 proposed rule (64 FR 24716) and in the July 30, 1999 final rule (64 FR 41490), is to prevent inappropriate Medicare payment to hospitals having a large number of such stays.

In the existing regulations at § 413.40(a)(3), we state that the 5-percent threshold is determined based on the total number of discharges from the hospital-within-a-hospital. We have received questions as to whether, in determining whether the threshold is met, we consider Medicare patients only or all patients (Medicare and non-Medicare). To avoid any further misunderstanding, we are clarifying the definition of ''ceiling'' in § 413.40(a)(3) by specifying that the 5-percent threshold is based on the *Medicare* inpatients discharged from the hospital-within-a-hospital in a particular cost reporting period, not on total Medicare and non-Medicare inpatient discharges.

C. Critical Access Hospitals (CAHs)

1. Election of Payment Method (§ 413.70)

Section 1834(g) of the Act, as in effect before enactment of Public Law 106–113, provided that the amount of payment for outpatient CAH services is the reasonable costs of the CAH in providing such services. However, the reasonable costs of the CAH's services to outpatients included only the CAH's costs of providing facility services, and did not include any payment for professional services. Physicians and other practitioners who furnished professional services to CAH outpatients billed the Part B carrier for these services and were paid under the physician fee schedule in accordance with the provisions of section 1848 of the Act.

Section 403(d) of Public Law 106–113 amended section 1834(g) of the Act to permit the CAH to elect to be paid for its outpatient services under another option. CAHs making this election would be paid amounts equal to the sum of the following, less the amount that the hospital may charge as described in section 1866(a)(2)(A) of the Act (that is, Part A and Part B deductibles and coinsurance):

(1) For facility services, not including any services for which payment may be made as outpatient professional services, the reasonable costs of the CAH in providing the services; and

(2) For professional services otherwise included within outpatient CAH services, the amounts that would otherwise be paid under Medicare if the services were not included in outpatient CAH services.

Section 403(d) of Public Law 106–113 added section 1834(g)(3) to the Act to further specify that payment amounts under this election are be determined without regard to the amount of the customary or other charge.

The amendment made by section 403(d) is effective for cost reporting periods beginning on or after October 1, 2000.

We are proposing to revise § 413.70 to incorporate the provisions of section 403(d) of Public Law 106–113. The existing § 413.70 specifies a single set of reasonable cost basis payment rules applicable to both inpatient and outpatient services furnished by CAHs. As section 403(d) of Public Law 106–113 provides that CAHs may elect to be paid on a reasonable cost basis for facility services and on a fee schedule basis for professional services, we are proposing to revise the section to allow for separate payment rules for CAH inpatient and outpatient services.

We are proposing to place the provisions of existing § 413.70(a) and (b) that relate to payment on a reasonable cost basis for inpatient services furnished by a CAH under proposed § 413.70(a). Proposed § 413.70(a)(2) would also state that payment to a CAH for inpatient services does not include professional services to CAH inpatients and is subject to the Part A hospital deductible and coinsurance determined under 42 CFR part 409, Subpart G.

We are proposing to include under § 413.70(b) the payment rules for outpatient services furnished by CAHs, including the option for CAHs to elect to be paid on the basis of reasonable costs for facility services and on the basis of the physician fee schedule for professional services. Under proposed § 413.70(b)(2), we would retain the existing provision that unless the CAH elects the option provided for under section 403 of Public Law 106–113, payment for outpatient CAH services is on a reasonable cost basis, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in Parts 413 and 415 (except for certain payment principles that do not apply; that is, the lesser of costs or charges, RCE limits, any type of reduction to operating or capital costs under § 413.124 or § 413.130(j)(7), and blended payment amounts for ambulatory surgical center services, radiology services, and other diagnostic services.

Under proposed § 413.70(b)(3), we would specify that any CAH that elects to be paid under the optional method must make an annual request in writing, and deliver the request for the election to the fiscal intermediary at least 60 days before the start of the affected cost reporting period. In addition, proposed § 413.70(b)(3) states that if a CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following two amounts:

- For facility services, not including any outpatient professional services for which payment may be made on a fee schedule basis, the amount would be the reasonable costs of the services as determined in accordance with applicable principles of cost reimbursement in 42 CFR Parts 413 and 415, except for certain payment principles that would not apply as specified above; and
- For professional services, otherwise payable to the physician or other practitioner on a fee schedule basis, the amounts would be those amounts that would otherwise be paid for the services if the CAH had not elected payment under this method.

We would also specify that payment to a CAH for outpatient services would be subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152, 410.160, and 410.161. Final payment to the CAH for its facility services to inpatients and outpatients furnished during a cost reporting would be based on a cost report for that period, as required under § 413.20(b).

2. Condition of Participation: Organ, Tissue, and Eye Procurement (§ 485.643)

Sections 1820(c)(2)(B) and 1861(mm) of the Act set forth the criteria for designating a CAH. Under this authority, the Secretary has established in regulations the minimum requirements a CAH must meet to participate in Medicare (42 CFR part 485, Subpart F).

Section 1905(a) of the Act provides that Medicaid payments may be made for any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary. The Secretary has specified CAH services as Medicaid services in regulations, specifically, the regulations at 42 CFR 440.170(g)(1)(i), and defined CAH services under Medicaid as those services furnished by a provider

meeting the Medicare conditions of participation (CoP).

Section 1138 of the Act provides that a CAH participating in Medicare must establish written protocols to identify potential organ donors that: (1) Assures that potential donors and their families are made aware of the full range of options for organ or tissue donation as well as their rights to decline donation; (2) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of those families; and (3) require that an organ procurement agency designated by the Secretary be notified of potential organ donors.

On June 22, 1998, as part of the Medicare hospital conditions of participation under Part 482, subpart C, we added to the regulations at § 482.45, a condition that specifically addressed organ, tissue, and eye procurement. However, Part 482 does not apply to CAHs, as CAHs are a distinct type of provider with separate CoP under Part 485. Therefore, we are proposing to add a CoP for organ, tissue, and eye procurement for CAHs at a new § 485.643 that generally parallels the CoP at § 482.45 for all Medicare hospitals with respect to the statutory requirement in section 1138 of the Act concerning organ donation. CAHs are not full service hospitals and therefore are not equipped to perform organ transplantations. Therefore, we are not including the standard applicable to Medicare hospitals that CAHs must be a member of the Organ Procurement and Transplantation Network (OPTN), abide by its rules and provide organ transplant-related data to the OPTN, the Scientific Registry, organ procurement agencies, or directly to the Department on request of the Secretary.

The proposed CoP for CAHs includes several requirements designed to increase organ donation. One of these requirements is that a CAH must have an agreement with the Organ Procurement Organization (OPO) designated by the Secretary, under which the CAH will contact the OPO in a timely manner about individuals who die or whose death is imminent. The OPO will then determine the individual's medical suitability for donation. In addition, the CAH must have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes, as long as the agreement does not interfere with organ donation. The proposed CoP would require a CAH to ensure, in collaboration with the OPO with which it has an agreement, that the family of every potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The CAH may choose to have OPO staff perform this function, have CAH and OPO staff jointly perform this function, or rely exclusively on CAH staff. Research indicates that consent to organ donation is highest when the formal request is made by OPO staff or by OPO staff and hospital staff together. While we require collaboration, we also recognize that CAH staff may wish to perform this function and may do so when properly trained. Moreover, the CoP would require the CAH to ensure that CAH employees who initiate a request for donation to the family of a potential donor have been trained as designated requestors.

Finally, the CoP would require the CAH to work with the OPO and at least one tissue bank and one eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of organs and tissues is underway.

We are sensitive to the possible burden this proposed CoP may place on CAHs. Therefore, we are particularly interested in comments and information concerning the following requirements: (1) Developing written protocols for donations; (2) developing agreements with OPOs, tissue banks, and eye banks; (3) referring all deaths to the OPO; (4) working cooperatively with the designated OPO, tissue bank, and eye bank in educating staff on donation issues, reviewing death records, and maintaining potential donors. We note that the proposed requirement allow some degree of flexibility for the CAH. For example, the CAH would have the option of using an OPO-approved education program to train its own employees as routine requestors or deferring requesting services to the OPO, the tissue bank, or the eye bank to provide requestors.

VII. MedPAC Recommendations

We have reviewed the March 1, 2000 report submitted by MedPAC to Congress and have given it careful consideration in conjunction with the proposals set forth in this document. MedPAC's recommendations and our responses are set forth below.

We note that MedPAC's March 1, 2000 report did not contain a recommendation concerning the update factors for inpatient hospital operating costs under the prospective payment system or for hospitals and hospital units excluded from the prospective payment system. However, at its April 13, 2000 public meeting, MedPAC announced that it was recommending a combined update of between 3.5 percent and 4.0 percent for operating and capital-related payments for FY 2001. This recommendation is higher than the current law amount as prescribed by Public Law 105–33 and proposed in this rule. Because of the timing of MedPAC's announcement in relation to the publication of this proposed rule, we intend to respond to MedPAC's recommendation in the FY 2001 final rule to be issued in August 2000 when we will have had the opportunity to review the data analyses that substantiate MedPAC's recommendation.

A. Combined Operating and Capital Prospective Payment Systems (Recommendation 3J)

Recommendation: The Congress should combine prospective payment system operating and capital payment rates to create a single prospective rate for hospital inpatient care. This change would require a single set of payment adjustments—in particular, for indirect medical education and disproportionate share hospital payments—and a single payment update.

Response: We responded to a similar comment in the July 30, 1999 final rule (64 FR 41552), the July 31, 1998 final rule (63 FR 41013), and the September 1, 1995 final rule (60 FR 45816). In those rules, we stated that our long-term goal was to develop a single update framework for operating and capital prospective payments and that we would begin development of a unified framework. However, we have not yet developed such a single framework as the actual operating system update has been determined by Congress through FY 2002. In the meantime, we intend to maintain as much consistency as possible with the current operating framework in order to facilitate the eventual development of a unified framework. We maintain our goal of combining the update frameworks at the end of the 10-year capital transition period (the end of FY 2001) and may examine combining the payment systems post-transition. Because of the similarity of the update frameworks, we believe that they could be combined with little difficulty.

In the discussion of its recommendation, MedPAC notes that it ''is examining broad reforms to the prospective payment system, including DRG refinement and modifications of the graduate medical education payment and the IME and DSH adjustments. The Commission believes that a combined hospital prospective payment rate should be established

whether or not broader reforms are undertaken. However, if the Congress acts on any or all of the Commission's recommendations, it should consider combining operating and capital payments as part of a larger package.''

We agree that ultimately the operating and capital prospective payment systems should be combined into a single system. However, we believe that, because of MedPAC's ongoing analysis and the Administration's pending DSH report to Congress, any such unification should occur within the context of other system refinements.

B. Continuing Postacute Transfer Payment Policy (Recommendation 3K)

Recommendation: The Commission recommends continuing the existing policy of adjusting per case payments through an expanded transfer policy when a short length of stay results from a portion of the patient's care being provided in another setting.

Response: As noted in section IV.A. of this preamble, we have undertaken (through a contract with HER) an analysis of the impact on hospitals and hospital payments of the postacute transfer provision. That analysis (based on preliminary data covering only approximately 6 months of discharge data) showed a minimal impact on the rate of short-stay postacute transfers after implementation of the policy. However, average profit margins as measured by HER declined from $2,454 prior to implementation of the policy to $1,180 after implementation. We believe these preliminary findings demonstrate that the postacute transfer provision has had only marginal impact on existing practice patterns while more closely aligning the payments to hospitals for these cases with the costs incurred. Therefore, we agree with MedPAC's recommendation that the policy should be continued.

C. Disproportionate Share Hospitals (DSH) (Recommendations 3L and 3M)

Recommendation: To address longstanding problems and current legal and regulatory developments, Congress should reform the disproportionate share adjustment to: include the costs of all poor patients in calculating low-income shares used to distribute disproportionate share payments, and use the same formula to distribute payments to all hospitals covered by prospective payment.

Response: As we noted in section IV.E. of this preamble, Public Law 106–113 directed the Secretary to require subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Act) to submit data on costs incurred for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-Medicare bad debt, charity care, and charges for Medicaid and indigent care. These data must be reported on the hospital's cost reports for cost reporting periods beginning on or after October 1, 2001, and will provide information that will enable MedPAC and us to evaluate potential refinements to the DSH formula to address issues referred to by MedPAC.

Medicare fiscal intermediaries will audit these data to ensure their accuracy and consistency. Our experience with administering the current DSH formula leads us to believe that this auditing function would necessarily be extensive, because the non-Medicare data that would be collected have never before been collected and reviewed by Medicare's fiscal intermediaries. The data would have to be determined to be accurate and usable, and corrected if necessary.

We agree that the current statutory payment formula could be improved, largely because of different threshold levels and different formula parameters applicable to different groups of hospitals. We are in the process of preparing a report to Congress on the Medicare DSH adjustment that includes several options for amending the statutory formula.

Recommendation: To provide further protection for the primarily voluntary hospitals with mid-level low-income shares, the minimum value, or threshold, for the low-income share that a hospital must have before payment is made should be set to make 60 percent of hospitals eligible to receive disproportionate share payments.

Response: Currently, approximately less than 40 percent of all prospective payment system hospitals receive DSH payments. Therefore, this recommendation would entail significant redistributions of existing DSH payments if implemented in a budget neutral manner. We are particularly concerned about the effect of this recommendation on hospitals receiving substantial DSH payments currently, including major teaching hospitals and public hospitals. The analysis by MedPAC demonstrates that these hospitals would be negatively impacted if more hospitals were made eligible for DSH payments.

VIII. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at http://www.hcfa.gov/stats/pubfiles.html. Data files are listed below with the cost of each. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to HCFA–PUF) to cover the cost to the following address: Health Care Financing Administration, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, Maryland 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. Expanded Modified MedPAR-Hospital (National)

The Medicare Provider Analysis and Review (MedPAR) file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services in the United States. (The file is a Federal fiscal year file, that is, discharges occurring October 1 through September 30 of the requested year.) The records are stripped of most data elements that would permit identification of beneficiaries. The hospital is identified by the 6-position Medicare billing number. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Uses for an Existing System of Records published in the **Federal Register** on December 24, 1984 (49 FR 49941), and amended by the July 2, 1985 notice (50 FR 27361). The national file consists of approximately 11 million records. Under the requirements of these notices, an agreement for use of HCFA Beneficiary Encrypted Files must be signed by the purchaser before release of these data. For all files requiring a signed agreement, please write or call to obtain a blank agreement form before placing an order. Two versions of this file are created each year. They support the following:

- Notice of Proposed Rulemaking (NPRM) published in the **Federal Register**. This file, scheduled to be available by the end of April, is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**. The FY 1999 MedPAR file used for the FY 2001 final rule will be cut off 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge
File Cost: $3,655.00 per fiscal year

Periods Available: FY 1988 through FY 1999

2. Expanded Modified MedPAR-Hospital (State)

The State MedPAR file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services in a particular State. The records are stripped of most data elements that will permit identification of beneficiaries. The hospital is identified by the 6-position Medicare billing number. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Uses for an Existing System of Records published in the December 24, 1984 **Federal Register** notice, and amended by the July 2, 1985 notice. This file is a subset of the Expanded Modified MedPAR-Hospital (National) as described above. Under the requirements of these notices, an agreement for use of HCFA Beneficiary Encrypted Files must be signed by the purchaser before release of these data. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**. This file, scheduled to be available by the end of April, is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**. The FY 1999 MedPAR file used for the FY 2001 final rule will be cut off 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge
File Cost: $1,130.00 per State per year
Periods Available: FY 1988 through FY 1999

3. HCFA Wage Data

This file contains the hospital hours and salaries for FY 1997 used to create the proposed FY 2001 prospective payment system wage index. The file will be available by the beginning of February for the NPRM and the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
2000	1997	2001
1999	1996	2000
1998	1995	1999
1997	1994	1998
1996	1993	1997
1995	1992	1996
1994	1991	1995
1993	1990	1994
1992	1989	1993
1991	1988	1992

These files support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/most recent year on the Internet

File Cost: $165.00 per year

Periods Available: FY 2001 PPS Update

4. HCFA Hospital Wages Indices (Formerly: Urban and Rural Wage Index Values Only)

This file contains a history of all wage indices since October 1, 1983.

Media: Diskette/most recent year on the Internet

File Cost: $165.00 per year

Periods Available: FY 2001 PPS Update

5. PPS SSA/FIPS MSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, and a historical list of Metropolitan Statistical Area (MSA).

Media: Diskette/Internet

File Cost: $165.00 per year

Periods Available: FY 2001 PPS Update

6. Reclassified Hospitals New Wage Index (Formerly: Reclassified Hospitals by Provider Only)

This file contains a list of hospitals that were reclassified for the purpose of assigning a new wage index. Two versions of these files are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/Internet

File Cost: $165.00 per year

Periods Available: FY 2001 PPS Update

7. PPS–IV to PPS–XII Minimum Data Set

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare participating hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

MEDIA: TAPE/CARTRIDGE

	Periods beginning on or after	and before
PPS–IV	10/01/86	10/01/87
PPS–V	10/01/87	10/01/88
PPS–VI	10/01/88	10/01/89
PPS–VII	10/01/89	10/01/90
PPS–VIII	10/01/90	10/01/91
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XIII	10/01/94	10/01/95

(**Note:** The PPS–XIII, PPS–XIV, and PPS–XV Minimum Data Sets are part of the PPS–XIII, PPS–XIV, and PPS–XV Hospital Date Set Files).

File Cost: $770.00 per year

8. PPS–IX to PPS–XII Capital Data Set

The Capital Data Set contains selected data for capital-related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

MEDIA: TAPE/CARTRIDGE

	Periods beginning on or after	and before
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XII	10/01/94	10/01/95

(**Note:** The PPS–XIII, PPS–XIV, and PPS–XV Capital Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV Hospital Data Set files.)

File Cost: $770.00 per year

9. PPS–XIII to PPS–XV Hospital Data Set

The file contains cost, statistical, financial, and other data from the Medicare Hospital Cost Report. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare-certified hospital by the Medicare fiscal intermediary to HCFA. The data set are updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Diskette/Internet

File Cost: $2,500.00

	Periods beginning on or after	and before
PPS–XIII	10/01/95	10/01/96
PPS–XIV	10/01/96	10/01/97
PPS–XV	10/01/97	10/01/98

10. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.

Media: Diskette/Internet
File Cost: $265.00
Periods Available: FY 2001 PPS Update

11. HCFA Medicare Case-Mix Index File

This file contains the Medicare case-mix index by provider number as published in each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/most recent year on Internet
Price: $165.00 per year/per file
Periods Available: FY 1985 through FY 1999

12. DRG Relative Weights (Formerly Table 5 DRG)

This file contains a listing of DRGs, DRG narrative description, relative weights, and geometric and arithmetic mean lengths of stay as published in the **Federal Register**. The hard copy image has been copied to diskette. There are two versions of this file as published in the **Federal Register:**

- NPRM.
- Final rule.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2001 PPS Update

13. PPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register**. This file is available for release 1 month after the proposed and final rules are published in the **Federal Register**.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2001 PPS Update

14. AOR/BOR Tables

This file contains data used to develop the DRG relative weights. It contains mean, maximum, minimum, standard deviation, and coefficient of variation statistics by DRG for length of stay and standardized charges. The BOR tables are ''Before Outliers Removed'' and the AOR is ''After Outliers Removed.'' (Outliers refers to statistical outliers, not payment outliers.) Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2001 PPS Update

For further information concerning these data tapes, contact The HCFA Public Use Files Hotline at (410) 786–3691.

Commenters interested in obtaining or discussing any other data used in constructing this rule should contact Stephen Phillips at (410) 786–4531.

B. Information Collection Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.
- We are soliciting public comment on each of these issues for the sections that contain information collection requirements.

Section 412.77, Determination of the Hospital-Specific Rate for Inpatient Operating Costs for Certain Sole Community Hospitals Based on a Federal Fiscal Year 1996 Base Period, and 412.92, Special Treatment: Sole Community Hospitals

Sections 412.77(a)(2) and 412.92(d)(1)(ii) state that an otherwise eligible hospital that elects not to receive payment based on its hospital-specific rate as determined under § 412.77 must notify its fiscal intermediary of its decision prior to the beginning of its cost reporting period beginning on or after October 1, 2000.

We estimate that it will take each hospital that notifies its intermediary of its election not to receive payments based on its hospital-specific rate as determined under § 412.77 an hour to draft and send its notice. However, we are unable at this time to determine how many hospitals will make this election and, therefore, will need to notify their intermediaries of their decision.

Section 485.643, Condition of Participation: Organ, Tissue, and Eye Procurement

It is important to note that because of the inherent flexibility of this proposed regulation, the extent of the information collection requirements is dependent upon decisions that will be made either by the CAH or by the CAH in conjunction with the OPO or the tissue and eye banks, or both. Thus, the paperwork burden on individual CAHs will vary and is subject, in large part, to their decisionmaking.

The burden associated with the requirements of this section include: (1) The requirement to maintain protocol documentation demonstrating that the five requirements of this section have been met; (2) the requirement for a CAH to notify an OPO, a tissue bank, or an eye bank of any imminent or actual death; and (3) the time required for a hospital to document and maintain OPO referral information.

We estimate that, on average, the requirement to maintain protocol documentation demonstrating that the requirements of this section have been met will impose one hour of burden on each CAH (on 161 CAHs) on an annual basis (a total of 161 annual burden hours).

The CoP in this section would require CAHs to notify the OPO about every

death that occurs in the CAH. The average Medicare hospital has approximately 165 beds and 200 deaths per year. However, by statute and regulation, CAHs may use no more than 15 beds for acute care services. Assuming that the number of deaths in a hospital is related to the number of acute care beds, there should be approximately 18 deaths per year in the average CAH. We estimated that the average notification telephone call to the OPO takes 5 minutes. Based on this estimate, a CAH would need approximately 90 minutes per year to notify the OPO about all deaths and imminent deaths.

Under the proposed CoP, a CAH may agree to have the OPO determine medical suitability for tissue and eye donation or may have alternative arrangements with a tissue bank and an eye bank. These alternative arrangements could include the CAH's direct notification of the tissue and eye bank of potential tissue and eye donors or direct notification of all deaths. If a CAH chose to contact both a tissue bank and an eye bank directly on all deaths, it would need an additional 6 hours per year (that is, 5 minutes per call) in order to call both the tissue and eye bank directly. Again, the impact is small, and the proposed regulation permits the CAH to decide how this process will take place. Note that many communities already have a one-phone call system in place. In addition, some OPOs are also tissue banks or eye banks, or both. A CAH that chose to use the OPO's tissue and eye bank services in these localities would need to make only one telephone call on every death.

We estimate that additional time would be needed by the CAH to annotate the patient record or fill out a form regarding the disposition of a call to the OPO or the tissue bank or the eye bank, or both. This recordkeeping should take no more than 5 minutes per call. Therefore, the paperwork burden associated with the call(s) would add up to an additional 270 minutes per year per CAH.

In summary, the information collection requirements of this section would be a range of from 3 to 9 hours per CAH, or 483 to 1,449 hours annually nationally.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following addresses:

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: John Burke HCFA–1118-P; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503. Attn: Allison Herron Eydt, HCFA Desk Officer.

These new information collection and recordkeeping requirements have been submitted to the Office of Management and Budget (OMB) for review under the authority of PRA. We have submitted a copy of the proposed rule to OMB for its review of the information collection requirements. These requirements will not be effective until they have been approved by OMB.

The requirements associated with a hospital's application for a geographic redesignation, codified in Part 412, are currently approved by OMB under OMB approval number 0938–0573, with an expiration date of September 30, 2002.

C. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the **DATES** section of this preamble and respond to those comments in the preamble to that rule. We emphasize that section 1886(e)(5) of the Act requires the final rule for FY 2001 to be published by August 1, 2000, and we will consider only those comments that deal specifically with the matters discussed in this proposed rule.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant programs—health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Chapter IV is proposed to be amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as follows:

1. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 412.2 is amended by revising the last sentence of paragraph (a) to read as follows:

§ 412.2 Basis of payment.

(a) *Payment on a per discharge basis.* * * * An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that are extraordinarily costly to treat.

* * * * *

§ 412.4 [Amended]

3. In § 412.4(f)(3), the reference to ''§ 412.2(e)'' is removed and '' 412.2(b)'' is added in its place.

4. Section 412.63 is amended by:

a. Revising paragraph (s);

b. Redesignating paragraphs (t), (u), (v), and (w) as paragraphs (u), (v), (w), and (x) respectively; and

c. Adding a new paragraph (t), to read as follows:

§ 412.63 Federal rates for inpatient operating costs for fiscal years after Federal fiscal year 1984.

* * * * *

(s) *Applicable percentage change for fiscal year 2001.* The applicable percentage change for fiscal year 2001 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for sole community hospitals and the increase in the market basket index minus 1.1 percentage points for other hospitals in all areas.

(t) *Applicable percentage change for fiscal year 2002.* The applicable percentage change for fiscal year 2002 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 1.1 percentage points for hospitals in all areas.

* * * * *

5. Section 412.73 is amended by revising paragraph (c)(12) and adding paragraphs (c)(13), (c)(14), and (c)(15), to read as follows:

§ 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.

* * * * *

(c) *Updating base-year costs* * * *

(12) *For Federal fiscal years 1996 through 2000.* For Federal fiscal years

1996 through 2000, the update factor is the applicable percentage change for other prospective payment hospitals in each respective year as set forth in §§ 412.63(n) through (r).

(13) *For Federal fiscal year 2001.* For Federal fiscal year 2001, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter).

(14) *For Federal fiscal year 2002.* For Federal fiscal year 2002, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 1.1 percentage points.

(15) *For Federal fiscal year 2003 and for subsequent years.* For Federal fiscal year 2003 and subsequent years, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter).

* * * * *

§ 412.75 [Amended]

6. In § 412.75(d), the cross reference ''§ 412.73 (c)(5) through (c)(12)'' is removed and ''§ 412.75(c)(15)'' is added in its place.

§ 412.76 [Redesignated]

7. Section 412.76 is redesignated as a new § 412.78.

8. A new § 412.77 is added to read as follows:

§ 412.77 Determination of the hospital-specific rate for inpatient operating costs for certain sole community hospitals based on a Federal fiscal year 1996 base period.

(a) *Applicability.* (1) This section applies to a hospital that has been designated as a sole community hospital, as described in § 412.72, that received payment for its cost reporting period beginning during 1999 based on its hospital-specific rate for either fiscal year 1982 under § 412.73 or fiscal year 1987 under § 412.75, and that elects under paragraph (a)(2) of this section to be paid based on a fiscal year 1996 base period.

(2) Hospitals that are otherwise eligible for but elect not to receive payment on the basis of their Federal fiscal year 1996 updated costs per case must notify their fiscal intermediary of this decision prior to the beginning of their cost reporting period beginning on or after October 1, 2000, for which such payments would otherwise be made. If a hospital does not make the notification to its fiscal intermediary before the end of the cost reporting period, the hospital is deemed to have elected to have section 1886(b)(3)(I) of the Act apply to the hospital.

(3) This section applies only to cost reporting periods beginning on or after October 1, 2000.

(4) The formula for determining the hospital-specific costs for hospitals described under paragraph (a)(1) of this section is set forth in paragraph (f) of this section.

(b) *Base-period costs for hospitals subject to fiscal year 1996 rebasing.* (1) *General rule.* Except as provided in paragraph (b)(2) of this section, for each hospital eligible under paragraph (a) of this section, the intermediary determines the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1996 and before September 30, 1997, and computes the hospital-specific rate for purposes of determining prospective payment rates for inpatient operating costs as determined under § 412.92(d).

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 1997 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 1996 and before September 30, 1997, and does have a cost reporting period beginning on or after October 1, 1995 and before October 1, 1996, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. If that cost reporting period is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short cost reporting period. If a hospital has no cost reporting period beginning in fiscal year 1996, the hospital will not have a hospital-specific rate based on fiscal year 1996.

(c) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(d) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(e) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1996, the update factor is determined using the methodology set forth in § 412.73(c)(12) through (c)(15).

(f) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(g) *Phase-in of fiscal year 1996 base-period rate.* The intermediary calculates the hospital-specific rates determined on the basis of the fiscal year 1996 base period rate as follows:

(1) For Federal fiscal year 2001, the hospital-specific rate is the sum of 75 percent of the hospital-specific rate for fiscal year 1982 or fiscal year 1987 (the § 412.73 or § 412.75 target amount), plus 25 percent of the hospital-specific rate for fiscal year 1996 (the § 412.77 target amount).

(2) For Federal fiscal year 2002, the hospital-specific rate is the sum of 50 percent of the § 412.73 or § 412.75 target amount and 50 percent of the § 412.77 target amount.

(3) For Federal fiscal year 2003, the hospital-specific rate is the sum of 25 percent of the § 412.73 or § 412.75 target amount and 75 percent of the § 412.77 target amount.

(4) For Federal fiscal year 2004 and any subsequent fiscal years, the hospital-specific rate is 100 percent of the § 412.77 target amount.

(h) *Notice of hospital-specific rates.* The intermediary furnishes a hospital eligible for rebasing a notice of the hospital-specific rate as computed in accordance with this section. The notice will contain a statement of the hospital's Medicare Part A allowable inpatient operating costs, the number of Medicare discharges, and the case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 1996 base period.

(i) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to a hospital upon receipt of the notice of the hospital-specific rate. This notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter.

(j) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the

hospital's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for the recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the hospital's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of HCFA under§ 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (i)(1) and (i)(2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

9. Section 412.92 is amended by revising paragraph (d)(1) to read as follows:

§ 412.92 Special treatment: sole community hospitals.

* * * * *

(d) *Determining prospective payment rates for inpatient operating costs for sole community hospitals.* (1) *General rules.* (i) Except as provided in paragraph (d)(1)(ii) of this section, for cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:

(A) The Federal payment rate applicable to the hospitals as determined under § 412.63.

(B) The hospital-specific rate as determined under § 412.73.

(C) The hospital-specific rate as determined under § 412.75.

(ii) For cost reporting periods beginning on or after October 1, 2000, a sole community hospital that was paid for its cost reporting period beginning during 1999 on the basis of the hospital-specific rate specified in paragraph (d)(1)(i)(B) or (d)(1)(i)(C) of this section, may elect to use the hospital-specific rate as determined under § 412.77.

* * * * *

10. Section 412.105 is amended by:

a. Revising paragraph (d)(3)(v);

b. Republishing paragraph (f)(1) introductory text and revising paragraph (f)(1)(vii);

c. Adding new paragraphs (f)(1)(viii) and (f)(1)(ix); and

d. Revising paragraph (g), to read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(d) *Determination of education adjustment factor* * * *

(3) * * *

(v) For discharges occurring during fiscal year 2001, 1.54.

* * * * *

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:

* * * * *

(vii) If a hospital establishes a new medical residency training program, as defined in § 413.86(g)(9) of this subchapter, the hospital's full-time equivalent cap may be adjusted in accordance with the provisions of §§ 413.86(g)(6) (i) through (iv) of this subchapter.

(viii) A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its full-time equivalent cap in accordance with the provisions of § 413.86(g)(7) of this subchapter.

(ix) A hospital may receive a temporary adjustment to its full-time equivalent cap to reflect residents added because of another hospital's closure if the hospital meets the criteria specified in § 413.86(g)(8) of this subchapter.

* * * * *

(g) *Indirect medical education payment for managed care enrollees.* For portions of cost reporting periods occurring on or after January 1, 1998, a payment is made to a hospital for indirect medical education costs, as determined under paragraph (e) of this section, for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act or with a Medicare+Choice organization under title XVIII, Part C of the Act during the period, according to the applicable payment percentages described in §§ 413.86(d)(3)(i) through (d)(3)(v) of this subchapter.

11. In § 412.106, the introductory text of paragraph (e) is republished and paragraphs (e)(4) and (e)(5) are revised to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(e) *Reduction in payment for FYs 1998 through 2002.* The amounts otherwise payable to a hospital under paragraph (d) of this section are reduced by the following:

* * * * *

(4) For FY 2001, 3 percent.

(5) For FY 2002, 4 percent.

* * * * *

12. Section 412.230 is amended by:

a. Republishing the introductory text of paragraph (e)(1); and

b. Revising paragraph (e)(1)(iii) and (e)(1)(iv)(A), to read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

* * * * *

(e) *Use of urban or other rural area's wage index—(1) Criteria for use of area's wage index.* Except as provided in paragraphs (e)(3) and (e)(4) of this section, to use an area's wage index, a hospital must demonstrate the following:

* * * * *

(iii) The hospital's average hourly wage is, in the case of a hospital located in a rural area, at least 106 percent, and, in the case of a hospital located in an urban area, at least 108 percent of the average hourly wage of hospitals in the

area in which the hospital is located; and

(iv) * * *

(A) The hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 82 percent, and in the case of a hospital located in an urban area, at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

B. Part 413 is amended as follows:

1. The authority citation for Part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

2. In § 413.40, paragraph (a)(3) is amended by revising paragraph (B) in the definition of ''ceiling'' and paragraph (d)(4) is revised, to read as follows:

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) *Introduction.* * * *

(3) *Definitions.* * * *

Ceiling. * * *

(B) The hospital-within-a-hospital has discharged to the other hospital and subsequently readmitted more than 5 percent (that is, in excess of 5.0 percent) of the total number of Medicare inpatients discharged from the hospital-within-a-hospital in that cost reporting period.

* * * * *

(d) *Application of the target amount in determining the amount of payment.* * * *

(4) *Continuous improvement bonus payments.* (i) For cost reporting periods beginning on or after October 1, 1997 and ending before October 1, 2000, eligible hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of—

(A) 50 percent of the amount by which the operating costs are less than the expected costs for the period; or

(B) 1 percent of the ceiling.

(ii) For cost reporting periods beginning on or after October 1, 2000, and ending before October 1, 2001, eligible psychiatric hospitals and units and long-term care hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of—

(A) 50 percent of the amount by which the operating costs are less than the expected costs for the period; or

(B) 1.5 percent of the ceiling.

(iii) For cost reporting periods beginning on or after October 1, 2001, and ending before October 1, 2002, eligible psychiatric hospitals and units and long-term care hospitals receive payments in addition to those in paragraph (d)(5) of this section, as applicable. These payments are equal to the lesser of—

(A) 50 percent of the amount by which the operating costs are less than the expected costs for the periods; or

(B) 2 percent of the ceiling.

* * * * *

3. Section 413.70 is revised to read as follows:

§ 413.70 Payment for services of a CAH.

(a) *Payment for inpatient services furnished by a CAH.* (1) Payment for inpatient services of a CAH is the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:

(i) Lesser of cost or charges;

(ii) Ceilings on hospital operating costs; and

(iii) Reasonable compensation equivalent (RCE) limits for physician services to providers.

(2) Payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients, and is subject to the Part A hospital deductible and coinsurance, as determined under subpart G of part 409 of this chapter.

(b) *Payment for outpatient services furnished by a CAH.* (1) *General.* Unless the CAH elects to be paid for services to its outpatients under the method specified in paragraph (b)(3) of this section, the amount of payment for outpatient services of a CAH is the amount determined under paragraph (b)(2) of this section.

(2) *Reasonable costs for facility services.* (i) Payment for outpatient services of a CAH is the reasonable costs of the CAH in providing CAH services to its outpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH outpatient services:

(A) Lesser of costs or charges;

(B) RCE limits;

(C) Any type of reduction to operating or capital costs under § 413.124 or § 413.130(j)(7); and

(D) Blended payment amounts for ambulatory surgical services, radiology services, and other diagnostic services;

(ii) Payment to a CAH under paragraph (b)(2) of this section does not include any costs of physician services or other professional services to CAH outpatients, and is subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152(k), 410.160, and 410.161 of this chapter.

(3) *Election to be paid reasonable costs for facility services plus fee schedule for professional services.* (i) A CAH may elect to be paid for outpatient services in any cost reporting period under the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section. This election must be made in writing, made on an annual basis, and delivered to the intermediary at least 60 days before the start of each affected cost reporting period. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and applies to all services furnished to outpatients during that period.

(ii) If the CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following amounts:

(A) For facility services, not including any services for which payment may be made under paragraph (b)(3)(ii)(B) of this section, the reasonable costs of the services as determined under paragraph (b)(2)(i) of this section; and

(B) For professional services otherwise payable to the physician or other practitioner on a fee schedule basis, the amounts that otherwise would be paid for the services if the CAH had not elected payment under this method.

(iii) Payment to a CAH is subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152, 410.160, and 410.161 of this chapter.

(c) *Final payment based on cost report.* Final payment to the CAH for CAH facility services to inpatients and outpatients furnished during a cost reporting is based on a cost report for that period, as required under § 413.20(b).

4. Section 413.86 is amended by:

a. Revising the first sentence of paragraph (d)(3);

b. Revising the introductory text of paragraph (e)(3);

c. Redesignating paragraph (e)(4) as paragraph (e)(5);

d. Adding a new paragraph (e)(4);

e. Revising newly designated paragraph (e)(5)(i)(B); and

f. Adding a new paragraph (e)(5)(iv), to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(d) *Calculating payment for graduate medical education costs.* * * *

(3) *Step Three.* For portions of cost reporting periods occurring on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare+Choice organization under Title XVIII, Part C of the Act. * * *

* * * * *

(e) *Determining per resident amounts for the base period.* * * *

(3) *For cost reporting periods beginning on or after July 1, 1986.* Subject to the provisions of paragraph (e)(4) of this section, for cost reporting periods beginning on or after July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

* * * * *

(4) *For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005.* For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005, a hospital's per resident amount for each fiscal year is adjusted in accordance with the following provisions:

(i) *General provisions.* For purposes of § 413.86(e)(4)—

(A) *Weighted average per resident amount.* The weighted average per resident amount is established as follows:

(*1*) Using data from hospitals' cost reporting periods ending during FY 1997, HCFA calculates each hospital's single per resident amount by adding each hospital's primary care and non-primary care per resident amounts, weighted by its respective FTEs, and dividing by the sum of the FTEs for primary care and non-primary care residents.

(*2*) Each hospital's single per resident amount calculated under paragraph (e)(4)(i)(A)(*1*) of this section is standardized by the 1999 geographic adjustment factor for the physician fee schedule area (as determined under § 414.26 of this chapter) in which the hospital is located.

(*3*) HCFA calculates an average of all hospitals' standardized per resident amounts that are determined under paragraph (e)(4)(i)(A)(*2*) of this section. The resulting amount is the weighted average per resident amount.

(B) *Primary care/obstetrics and gynecology and non-primary care per resident amounts.* A hospital's per resident amount is an amount inclusive of any CPI–U adjustments that the hospital may have received since the hospital's base year, including any CPI–U adjustments the hospital may have received because the hospital trains primary care/obstetrics and gynecology residents and non-primary care residents as specified under paragraph (e)(3)(ii) of this section.

(ii) *Adjustment beginning in FY 2001 and ending in FY 2005.* For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005, a hospital's per resident amount is adjusted in accordance with paragraphs (e)(4)(ii)(A) through (e)(4)(ii)(C) of this section, in that order:

(A) *Updating the weighted average per resident amount for inflation.* The weighted average per resident amount (as determined under paragraph (e)(4)(i)(A) of this section) is updated by the estimated percentage increase in the CPI–U during the period beginning with the month that represents the midpoint of the cost reporting periods ending during FY 1997 (that is, October 1, 1996) and ending with the midpoint of the hospital's cost reporting period that begins in FY 2001.

(B) *Adjusting for locality.* The updated weighted average per resident amount determined under paragraph (e)(4)(ii)(A) of this section (the national average per resident amount) is adjusted for the locality of each hospital by multiplying the national average per resident amount by the 1999 geographic adjustment factor for the physician fee schedule area in which each hospital is located, established in accordance with § 414.26 of this subchapter.

(C) *Determining necessary revisions to the per resident amount.* The locality-adjusted national average per resident amount, as calculated in accordance with paragraph (e)(4)(ii)(B) of this section, is compared to the hospital's per resident amount. Each hospital's per resident amount is revised, if appropriate, according to the following three categories:

(*1*) *Floor.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2001, if the hospital's per resident amount would otherwise be less than 70 percent of the locality-adjusted national average per resident amount for FY 2001 (as determined under paragraph (e)(4)(ii)(B) of this section), the per resident amount is equal to 70 percent of the locality-adjusted national average per resident amount for FY 2001. For subsequent cost reporting periods, the hospital's per resident amount is updated using the methodology specified under paragraph (e)(3)(i) of this section.

(*2*) *Ceiling.* If the hospital's per resident amount is greater than 140 percent of the locality-adjusted national average per resident amount, the per resident amount is adjusted as follows for FY 2001 through FY 2005:

(*i*) *FY 2001.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2001, if the hospital's FY 2000 per resident amount exceeds 140 percent of the FY 2001 locality-adjusted national average per resident amount (as calculated under paragraph (e)(4)(ii)(B) of this section), then, subject to the provision stated in paragraph (e)(4)(ii)(C)(*2*)(*iv*) of this section, the hospital's per resident amount is frozen at the FY 2000 per resident amount and is not updated for FY 2001 by the CPI–U factor.

(*ii*) *FY 2002.* For cost reporting periods beginning on or after October 1, 2001 and on or before September 30, 2002, if the hospital's FY 2001 per resident amount exceeds 140 percent of the FY 2002 locality-adjusted national average per resident amount, then, subject to the provision stated in paragraph (e)(4)(ii)(C)(*2*)(*iv*) of this section, the hospital's per resident amount is frozen at the FY 2001 per resident amount and is not updated for FY 2002 by the CPI–U factor.

(*iii*) *FY 2003 through FY 2005.* For cost reporting periods beginning on or after October 1, 2002 and on or before September 30, 2005, if the hospital's per resident amount for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average per resident amount for that same previous cost reporting period (for example, for cost reporting periods beginning in FY 2003, compare the hospital's per resident amount from the FY 2002 cost report to the hospital's locality-adjusted national average per resident amount from FY 2002), then, subject to the provision stated in paragraph (e)(4)(ii)(C)(*2*)(*iv*) of this section, the hospital's per resident amount is adjusted using the methodology specified in paragraph

(e)(3)(i) of this section, except that the CPI–U applied for a 12-month period is reduced (but not below zero) by 2 percentage points.

(*iv*) *General rule for hospitals that exceed the ceiling.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, if a hospital's per resident amount exceeds 140 percent of the hospital's locality-adjusted national average per resident amount and it is adjusted under any of the criteria under paragraphs (e)(4)(ii)(C)(*2*)(*i*) through (*iii*) of this section, the current year per resident amount resident amount cannot be reduced below 140 percent of the locality-adjusted national average per resident amount.

(*3*) *Per resident amounts greater than or equal to the floor and less than or equal to the ceiling.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, if a hospital's per resident amount is greater than or equal to 70 percent and less than or equal to 140 percent of the hospital's locality-adjusted national average per resident amount for each respective fiscal year, the hospital's per resident amount is updated using the methodology specified in paragraph (e)(3)(i) of this section.

(5) *Exceptions*—(i) *Base period for certain hospitals.* * * *

(B) The weighted mean value of per resident amounts of hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter, for cost reporting periods beginning in the same fiscal years. If there are fewer than three amounts that can be used to calculate the weighted mean value, the calculation of the per resident amounts includes all hospitals in the hospital's region as that term is used in § 412.62(f)(1)(i) of this chapter.

* * * * *

(iv) Effective October 1, 2000, the per resident amounts established under paragraphs (e)(5)(i) through (iii) of this section are subject to the provisions of paragraph (e)(4) of this section.

* * * * *

PART 485B—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

C. Part 485 is amended as follows:

1. The authority citation for part 485 continues to read as follows:

Authority: Sec. 1820 of the Act (42 U.S.C. 1395i–4), unless otherwise noted.

2. A new § 485.643 is added to subpart F to read as follows:

§ 485.643 Condition of participation: Organ, tissue, and eye procurement.

The CAH must have and implement written protocols that:

(a) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;

(b) Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;

(c) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;

(d) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;

(e) Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.

(f) For purposes of these standards, the term ''Organ'' means a human kidney, liver, heart, lung, or pancreas.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: April 14, 2000.

Nancy Ann Min DeParle,

Administrator, Health Care Financing Administration

Dated: April 28, 2000.

Donna E. Shalala,

Secretary.

[Editorial Note: The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Proposed Schedule of Standardized Amounts Effective With Discharges Occurring On or After October 1, 2000 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2000

I. Summary and Background

In this Addendum, we are setting forth the proposed amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. We are also setting forth proposed rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the prospective payment system.

For discharges occurring on or after October 1, 2000, except for sole community hospitals, Medicare-dependent, small rural hospitals, and hospitals located in Puerto Rico, each hospital's payment per discharge under the prospective payment system will be based on 100 percent of the Federal national rate.

Sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if qualified, 25 percent of the updated hospital-specific rate based on FY 1996 cost per discharge, plus 75 percent of the updated FY 1982 or FY 1987 hospital-specific rate. Section 405 of Public Law 106–113 amended section 1886(b)(3) of the Act to allow a sole community hospital that was paid for its cost reporting period beginning during FY 1999 on the basis of either its FY 1982 or FY 1987 hospital-specific rate to elect to rebase its hospital-specific rate based on its FY 1996 cost per discharge.

Section 404 of Public Law 106–113 amended section 1886(d)(5)(G) of the Act to extend the special treatment for Medicare-dependent, small rural hospitals. Therefore, Medicare-dependent, small rural hospitals are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference

between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 cost per discharge, whichever is higher.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate and 50 percent of a Federal national rate.

As discussed below in section II of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2001. The changes, to be applied prospectively, would affect the calculation of the Federal rates. In section III of this Addendum, we discuss updates to the payments per unit for blood clotting factor provided to hospital inpatients who have hemophilia. In section IV of this Addendum, we discuss our proposed changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2001. Section V of this Addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system for FY 2001. The tables to which we refer in the preamble to this proposed rule are presented at the end of this Addendum in section VI.

II. Proposed Changes to Prospective Payment Rates for Inpatient Operating Costs for FY 2001

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the proposed factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes, once issued as final, will be effective with discharges occurring on or after October 1, 2000. As required by section 1886(d)(4)(C) of the Act, we must also adjust the DRG classifications and weighting factors for discharges in FY 2001.

In summary, the proposed standardized amounts set forth in Tables 1A and 1C of section VI of this Addendum reflect—

- Updates of 2.0 percent for all areas (that is, the market basket percentage increase of 3.1 percent minus 1.1 percentage points);
- An adjustment to ensure budget neutrality as provided for in sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 2000 budget neutrality factor and applying a revised factor;
- An adjustment to apply the revised outlier offset by removing the FY 2000 outlier offsets and applying a new offset; and
- An adjustment in the Puerto Rico standardized amounts to reflect the application of a Puerto Rico-specific wage index.

The standardized amounts set forth in table 1E of section VI of this Addendum, which apply to sole community hospitals, reflect updates of 3.1 percent (that is, the full market basket percentage increase) as provided for in section 406 of Public Law 106–113, but otherwise reflect the same adjustments as the national standardized amounts.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates.

Section 1886(d)(9)(B)(i) of the Act required us to determine the Medicare target amounts for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule (52 FR 33043, 33066) contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates.

The standardized amounts are based on per discharge averages of adjusted hospital costs from a base period or, for Puerto Rico, adjusted target amounts from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections 1886(d)(2)(B) and (d)(2)(C) of the Act required us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients.

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, in making payments under the prospective payment system, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Since October 1, 1997, when the market basket was last revised, we have considered 71.1 percent of costs to be labor-related for purposes of the prospective payment system. The average labor share in Puerto Rico is 71.3 percent. We are proposing to revise the discharge-weighted national standardized amount for Puerto Rico to reflect the proportion of discharges in large urban and other areas from the FY 1999 MedPAR file.

2. Computing Large Urban and Other Area Averages

Sections 1886(d)(2)(D) and (d)(3) of the Act require the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge must be determined for hospitals located in urban and other areas in Puerto Rico. Hospitals in Puerto Rico are paid a blend of 50 percent of the applicable Puerto Rico standardized amount and 50 percent of a national standardized payment amount.

Section 1886(d)(2)(D) of the Act defines ''urban area'' as those areas within a Metropolitan Statistical Area (MSA). A ''large urban area'' is defined as an urban area with a population of more than 1 million. In addition, section 4009(i) of Public Law 100–203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Urban areas that do not meet the definition of a ''large urban area'' are referred to as ''other urban areas.'' Areas that are not included in MSAs are considered ''rural areas'' under section 1886(d)(2)(D) of the Act. Payment for discharges from hospitals located in large urban areas will be based on the large urban standardized amount. Payment for discharges from hospitals located in other urban and rural areas will be

based on the other standardized amount.

Based on 1997 population estimates published by the Bureau of the Census, 61 areas meet the criteria to be defined as large urban areas for FY 2001. These areas are identified by a footnote in Table 4A.

3. Updating the Average Standardized Amounts

Under section 1886(d)(3)(A) of the Act, we update the area average standardized amounts each year. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban areas' and the other areas' average standardized amounts for FY 2001 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XVI) of the Act specifies that the update factor for the standardized amounts for FY 2001 is equal to the market basket percentage increase minus 1.1 percentage points for hospitals, except sole community hospitals, in all areas. The Act, as amended by section 406 of Public Law 106–113, specifies an update factor equal to the market basket percentage increase for sole community hospitals.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2001 is 3.1 percent. Thus, for FY 2001, the proposed update to the average standardized amounts equals 3.1 percent for sole community hospitals and 2.0 percent for other hospitals.

As in the past, we are adjusting the FY 2000 standardized amounts to remove the effects of the FY 2000 geographic reclassifications and outlier payments before applying the FY 2001 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 2001.

Although the update factors for FY 2001 are set by law, we are required by section 1886(e)(3) of the Act to report to the Congress our initial recommendation of update factors for FY 2001 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we have included the report to Congress as Appendix C to this proposed rule. Our proposed recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix D to this proposed rule.

4. Other Adjustments to the Average Standardized Amounts

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, we used historical discharge data to simulate payments and compared aggregate payments using the FY 2000 relative weights and wage index to aggregate payments using the proposed FY 2001 relative weights and wage index. The same methodology was used for the FY 2000 budget neutrality adjustment. (See the discussion in the September 1, 1992 final rule (57 FR 39832).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.996506. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.999753. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2000 budget neutrality adjustments. We do not remove the prior budget neutrality adjustment because estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

In addition, we are proposing to apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2000. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

b. Reclassified Hospitals—Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the Medicare Geographic Classification Review Board (MGCRB). Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. Section 152(b) of Public Law 106–113 requires reclassifications under that subsection to be treated as reclassifications under section 1886(d)(10) of the Act. To calculate this budget neutrality factor, we used historical discharge data to simulate payments, and compared total prospective payments (including IME and DSH payments) prior to any reclassifications to total prospective payments after reclassifications. Based on these simulations, we are applying an adjustment factor of 0.994270 to ensure that the effects of reclassification are budget neutral.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 2000 budget neutrality adjustment factor. We note that the proposed FY 2001 adjustment reflects wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 29, 2000. The effects of any additional reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 2001 or from a hospital's request for the withdrawal of a reclassification request will be reflected in the final budget neutrality adjustment published in the final rule for FY 2001.

c. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases, cases involving extraordinarily high costs (cost outliers). Section 1886(d)(3)(B) of the Act requires the Secretary to adjust both the large urban and other area national standardized amounts by the same factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to adjust the large urban and other standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. Furthermore, under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total payments based on DRG prospective payment rates.

i. FY 2001 outlier thresholds. For FY 2000, the fixed loss cost outlier threshold was equal to the prospective payment for the DRG plus $14,050 ($12,827 for hospitals that have not yet entered the prospective payment system for capital-related costs). The marginal cost factor for cost outliers (the percent of costs paid after costs for the case exceed the threshold) was 80 percent. We applied an outlier adjustment to the FY 2000 standardized amounts of 0.948859 for the large urban and other areas rates and 0.9402 for the capital Federal rate.

For FY 2001, we propose to establish a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $17,250 ($15,763 for hospitals that have not yet entered the prospective payment system for capital-related costs). In addition, we propose to maintain the marginal cost factor for cost outliers at 80 percent.

To calculate FY 2001 outlier thresholds, we simulated payments by applying FY 2001 rates and policies to the December 1999 update of the FY 1999 MedPAR file and the December 1999 update of the provider-specific file. As we have explained in the past, to calculate outlier thresholds, we apply a cost inflation factor to update costs for the cases used to simulate payments. For FY 1999, we used a cost inflation factor of minus 1.724 percent. For FY 2000, we used a cost inflation factor (or cost adjustment factor) of zero percent. To set the proposed FY 2001 outlier thresholds, we are using a cost inflation factor of 1.0 percent. This factor reflects our analysis of the best available cost report data as well as calculations (using the best available data) indicating that the percentage of actual outlier payments for FY 1999 is higher than we projected before the beginning of FY 1999, and that the percentage of actual outlier payments for FY 2000 will likely be higher than we projected before the beginning of FY 2000. The calculations of ''actual'' outlier payments are discussed further below.

ii. Other changes concerning outliers. In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated proposed outlier thresholds so that outlier payments are projected to equal 5.1 percent of total payments based on DRG prospective payment rates. In accordance with section 1886(d)(3)(E), we reduced the proposed FY 2001 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both inpatient operating costs and inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 2001 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.8 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors to be applied to the standardized amounts for FY 2001 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948865	0.9416
Puerto Rico ...	0.975408	0.9709

We apply the proposed outlier adjustment factors after removing the effects of the FY 2000 outlier adjustment factors on the standardized amounts.

Table 8A in section VI of this Addendum contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the fiscal intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. These Statewide average ratios would replace the ratios published in the July 30, 1999 final rule (64 FR 41620). Table 8B contains comparable Statewide average capital cost-to-charge ratios. These average ratios would be used to calculate cost outlier payments for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios lower than 0.201132 or greater than 1.308495 and capital cost-to-charge ratios lower than 0.01266 or greater than 0.16901. This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. We note that the cost-to-charge ratios in Tables 8A and 8B would be used during FY 2001 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or outside the three standard deviations range.

iii. FY 1999 and FY 2000 outlier payments. In the July 30, 1999 final rule (64 FR 41547), we stated that, based on available data, we estimated that actual FY 1999 outlier payments would be approximately 6.3 percent of actual total DRG payments. This was computed by simulating payments using the March 1998 bill data available at the time. That is, the estimate of actual outlier payments did not reflect actual FY 1999 bills but instead reflected the application of FY 1999 rates and policies to available FY 1998 bills. Our current estimate, using available FY 1999 bills, is that actual outlier payments for FY 1999 were approximately 7.5 percent of actual total DRG payments. We note that the MedPAR file for FY 1999 discharges continues to be updated. Thus, the data indicate that, for FY 1999, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 1999 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 1999). In fact, the data indicate that the proportion of actual outlier payments for FY 1999 exceeds 6 percent. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the prospective payment system, we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 1999.

We currently estimate that actual outlier payments for FY 2000 will be approximately 6.1 percent of actual total DRG payments, higher than the 5.1 percent we projected in setting outlier policies for FY 2000. This estimate is based on simulations using the December 1999 update of the provider-specific file and the December 1999 update of the FY 1999 MedPAR file (discharge data for FY 1999 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2000 by applying FY 2000 rates and policies to available FY 1999 bills.

5. FY 2001 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A (Table 1E for sole community hospitals) contains the two national standardized amounts that we are proposing to be applicable to all hospitals, except hospitals in Puerto Rico. Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C. This table also includes the Puerto Rico standardized amounts.

B. Adjustments for Area Wage Levels and Cost of Living

Tables 1A, 1C and 1E, as set forth in this Addendum, contain the proposed labor-related and nonlabor-related shares that would be used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of this preamble, we discuss the data and methodology for the proposed FY 2001 wage index. The proposed wage index is set forth in Tables 4A through 4F of this Addendum.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2001, we propose to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below. If the Office of Personnel Management releases revised cost-of-living adjustment factors before July 1, 2000, we will publish them in the final rule and use them in determining FY 2001 payments.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.25
County of Hawaii	1.15
County of Kauai	1.225
County of Maui	1.225
County of Kalawao	1.225

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI of this Addendum contains the relative weights that we are proposing to use for discharges occurring in FY 2001. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 2001

General Formula for Calculation of Prospective Payment Rates for FY 2001

Prospective payment rate for all hospitals located outside of Puerto Rico except sole community hospitals and Medicare-dependent, small rural hospitals = Federal rate.

Prospective payment rate for sole community hospitals = Whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if the sole community hospital was paid for its cost reporting period beginning during FY 1999 on the basis of either its FY 1982 or FY 1987 hospital-specific rate and elects rebasing, 25 percent of its updated hospital-specific rate based on FY 1996 cost per discharge plus 75 percent of its updated FY 1982 or FY 1987 hospital-specific rate.

Prospective payment rate for Medicare-dependent, small rural hospitals = 100 percent of the Federal rate, or, if the greater of the updated FY 1982 hospital-specific rate or the updated FY 1987 hospital-specific rate is higher than the Federal rate, 100 percent of the Federal rate plus 50 percent of the difference between the applicable hospital-specific rate and the Federal rate.

Prospective payment rate for Puerto Rico = 50 percent of the Puerto Rico rate + 50 percent of a discharge-weighted average of the national large urban standardized amount and the Federal national other standardized amount.

1. Federal Rate

For discharges occurring on or after October 1, 2000 and before October 1, 2001, except for sole community hospitals, Medicare-dependent, small rural hospitals and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal national rate.

The payment amount is determined as follows:

Step 1—Select the appropriate national standardized amount considering the type of hospital and designation of the hospital as large urban or other (see Table 1A or 1E in section VI of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located (see Tables 4A, 4B, and 4C of section VI of this Addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if appropriate, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the appropriate DRG (see Table 5 of section VI of this Addendum).

2. Hospital-Specific Rate (Applicable Only to Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals)

Section 1886(b)(3)(C) of the Act, as amended by section 405 of Public Law 106–113, provides that sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, the updated hospital-specific rate based on FY 1987 cost per discharge, or, if the sole community hospital was paid for its cost reporting period beginning during FY 1999 on the basis of either its FY 1982 or FY 1987 hospital-specific